Provider Manual

ConnectiCare Marketplace

2026

This manual DOES NOT apply for Members with an ID number that begins with a “K”.

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in the Provider Agreement with ConnectiCare. “ConnectiCare” has the same meaning as “Health Plan” in the Provider Agreement with ConnectiCare. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at connecticare.com.

Last Updated: 09/2025

ConnectiCare

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1. Marketplace products

SOLO plan information

ConnectiCare offers affordable health plans off the CT Exchange:

- 2026 Choice SOLO POS HSA Coins. $6,500 ded. Bronze
- 2026 Choice SOLO HMO HSA $7,500 ded. Bronze
- 2026 Choice SOLO HMO Copay/Coins. $7,700 ded. Silver

CT Exchange plan information

ConnectiCare offers affordable Exchange plans:

- 2026 Choice Gold Standard POS
- 2026 Choice Gold Alternative POS
- 2026 Choice Bronze Standard POS
- 2026 Choice Bronze Alternative POS with Dental and Vision
- 2026 Choice Bronze Standard POS HSA
- 2026 Choice Catastrophic POS with Dental and Vision
- 2026 Choice Silver Standard POS
- 2026 Choice Silver Standard POS (CSR 73%)
- 2026 Choice Silver Standard POS (CSR 87%)
- 2026 Choice Silver Standard POS (CSR 94%)
- 2026 Value Gold Standard POS
- 2026 Value Bronze Standard POS
- 2026 Value Bronze Standard POS HSA
- 2026 Value Silver Standard POS
- 2026 Value Silver Standard POS (CSR 73%)
- 2026 Value Silver Standard POS (CSR 87%)
- 2026 Value Silver Standard POS (CSR 94%)
- 2026 Covered Connecticut Program (87)
- 2026 Covered Connecticut Program (94)
- 2026 Value Covered Connecticut Program (87)
- 2026 Value Covered Connecticut Program (94)

2. Contact information

ConnectiCare
175 Scott Swamp Road
PO Box 4050
Farmington, CT 06034-4050

Provider services

The ConnectiCare Provider Contact Center handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility, and general concerns. ConnectiCare Provider Contact Center representatives are available 8 a.m. to 6 p.m., ET, Monday through Friday, excluding state and federal holidays. Questions can also be submitted through the Secure Messaging feature on the Availity Essentials portal.

Phone: (800) 828-3407
Availity Essentials portal: availity.com/providers

Provider relations

The Provider Relations department manages Provider calls regarding issue resolution, Provider education and training. The department has Provider Relations representatives who serve all of ConnectiCare's Provider network.

Phone: (800) 828-3407

Member services

The ConnectiCare Member Contact Center handles all telephone inquiries regarding benefits, eligibility/identification, pharmacy inquiries, selecting or changing primary care providers (PCP) and Member complaints. ConnectiCare Member Contact Center representatives are available 8 a.m. to 6 p.m., ET, Monday through Friday, excluding state and federal holidays.

Phone: (800) 251-7722
Hearing Impaired (TTY/TDD): 711

Claims

For dates of services beginning 01/01/2026: ConnectiCare strongly encourages participating Providers to submit claims electronically via a clearinghouse or the Availity Essentials portal whenever possible.

- Availity Essentials portal: availity.com/providers
- EDI Payer ID MLNCT

To verify the status of your claims, please use the Availity Essentials portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status

module on the Availity Essentials portal or by contacting the ConnectiCare Provider Contact Center. For additional information please refer to the **Claims** section of this Provider Manual.

Phone: (800) 828-3407
Hearing Impaired (TTY/TDD): 711

Claims recovery

The Claims Recovery department manages recovery for overpayment and incorrect payment of claims.

Provider disputes	ConnectiCare PO Box 2470 Spokane, WA 99210-2470
Refund checks lockbox	ConnectiCare PO Box 416947 Boston, MA 02241-6947
Phone:	(866) 642-8999

Compliance and fraud alertline

Suspected cases of fraud, waste or abuse must be reported to ConnectiCare. You may do so by contacting the ConnectiCare Alertline or by submitting an electronic complaint using the website listed below. For additional information on fraud, waste and abuse please refer to the **Compliance** section of this Provider Manual.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: molinahealthcare.alertline.com

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years or sooner, depending on ConnectiCare's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the ConnectiCare network. For additional information, please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

24-hour Nurse Advice Line

This telephone-based nurse advice line is available to all ConnectiCare Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week.

Phone: (833) 957-0169
Hearing Impaired (TTY/TDD): 711

Health care services

The Health Care Services (HCS) department conducts concurrent review on inpatient cases and processes prior authorizations/service requests. The HCS department also performs case management for Members who will benefit from case management services. Participating Providers are required to interact with ConnectiCare's HCS department electronically whenever possible. Prior authorization/service requests and status checks can be easily managed electronically. For additional information please refer to the **Health Care Services** section of this Provider Manual.

Managing prior authorization/service requests electronically provides many benefits to providers, such as:

- Easy to access to 24/7 online submission and status checks
- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance
- Ability to receive real-time authorization status
- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces costs associated with fax and telephonic interactions

ConnectiCare offers the following electronic prior authorization/service request submission options:

- Submit requests directly to ConnectiCare via the Availity Essentials portal.
- Submit requests via 278 transactions.

Mental health and substance use disorder

ConnectiCare's vendor, Optum Behavioral Health, coordinates and manages behavioral health and substance abuse services for Members. Optum Behavioral Health has a Help Line that Members and Providers can access by calling (888) 946-4658. Standard hours of operation are 7 a.m. to 7 p.m., CST. When Members call this number at any time there is an IVR prompt that asks if they have concerns about their own or someone else's safety. If the Member answers YES, they are routed directly to a crisis team 24/7.

For Clinical Assistance, Providers can contact Optum Behavioral Health at (800) 349-5365 from 7 a.m. to 7 p.m., CST. For higher-level of care auth requests ONLY, Providers can call this number 24/7.

For additional information please refer to Optum's website at providerexpress.com.

Claims address:

Optum Behavioral Health
PO Box 30757
Salt Lake City, UT 84130-0757

Pharmacy

The prescription drug benefit is administered through CVS Caremark. A list of in-network pharmacies is available on the connecticare.com website or by contacting ConnectiCare. For additional information please refer to the **Pharmacy** section of this Provider Manual.

Phone: (888) 407-6425
Fax: (833) 896-0676

Quality

ConnectiCare maintains a Quality department to work with Members and Providers in administering the ConnectiCare Quality Improvement (QI) program. For additional information please refer to the **Quality** section of this Provider Manual.

Phone: (800) 828-3407

ConnectiCare service area

Fairfield
Hartford
Litchfield
Middlesex
New Haven
New London
Tolland
Windham

3. Provider responsibilities

Non-discrimination in health care service delivery

Providers must comply with the non-discrimination in health care service delivery requirements as outlined in the **Culturally and Linguistically Appropriate Services** section of this Provider Manual.

Additionally, ConnectiCare requires Providers to deliver services to ConnectiCare Members without regard to the source of payment. Specifically, Providers may not refuse to serve ConnectiCare Members because they receive assistance with cost-sharing from a government-funded program.

Section 1557 investigations

All ConnectiCare Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to ConnectiCare's Civil Rights Coordinator.

Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Hearing Impaired: TTY/TDD: 711
Online: molinahealthcare.alertline.com
Email: civil.rights@molinahealthcare.com

For additional information please refer to the Department of Health and Human Services (HHS) website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, equipment, personnel and administrative services

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider data accuracy and validation

It is important for Providers to ensure ConnectiCare has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider Network.

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA) required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate claim processing.

Please visit our Provider Online Directory to validate your information. Providers must validate their Provider information on file with ConnectiCare at least once every 90 days for correctness and completeness.

Failure to do so will result in your REMOVAL from the Provider Directory. Provider information that must be validated includes, but is not limited to:

- Provider or practice name
- Location(s)/address
- Specialty(ies)
- Telephone number, fax number and email
- Digital contact information
- Whether your practice is open to new patients (PCPs only)
- Tax ID and/or National Provider Identifier (NPI)

The information above must be provided as follows:

- Delegated Providers and other Providers that typically submit rosters must submit a full roster that includes the above information to ConnectiCare at cci-providerfileoperations@molinahealthcare.com.
- All other Providers must log into their Council for Affordable Quality Healthcare, Inc., (CAQH) account to attest to the accuracy of the above information for each health care Provider and/or facility in your practice that is contracted with ConnectiCare. If the information is correct, please select the option to attest that the information is correct. If the information is not correct, Providers can make updates through the CAQH portal. Providers unable to make updates through the CAQH portal should contact their ConnectiCare Provider Relations representative for assistance.

Additionally, in accordance with the terms specified in the Provider Agreement with ConnectiCare, Providers must notify ConnectiCare of any changes as soon as possible, but at a minimum 30 calendar days in advance of any changes in any Provider information on file with ConnectiCare. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax or email
- Addition or closure of office location(s)
- Addition of a Provider (within an existing clinic/practice)
- Change in Provider or practice name, Tax ID and/or NPI
- Opening or closing your practice to new patients (PCPs only)
- Change in specialty
- Any other information that may impact Member access to care

For Provider terminations (within an existing clinic/practice), Providers must notify ConnectiCare in writing in accordance with the terms specified in the Provider Agreement with ConnectiCare.

Note: Some changes may impact credentialing. Providers are required to notify ConnectiCare of changes to credentialing information in accordance with the requirements outlined in the **Credentialing and Recredentialing** section of this Provider Manual.

ConnectiCare is required to audit and validate our Provider network data and Provider directories on a routine basis. As part of our validation efforts, we may reach out to our network of Providers through various methods such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. ConnectiCare also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

ConnectiCare electronic solutions requirements

ConnectiCare requires Providers to utilize electronic solutions and tools whenever possible.

ConnectiCare requires all contracted Providers to participate in and comply with ConnectiCare's electronic solution requirements which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic claim submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic claim appeal and registration for and use of the Availity Essentials portal.

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Availity Essentials portal.

Any Provider entering the network as a Contracted Provider will be required to comply with ConnectiCare's electronic solution policy by enrolling for EFT/ERA payments and registering for the Availity Essentials portal within 30 days of entering the ConnectiCare network.

ConnectiCare is committed to complying with all HIPAA Transactions, Code Sets and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with ConnectiCare. Providers must obtain an NPI and use their NPI in HIPAA transactions, including claims submitted to ConnectiCare. Providers may obtain additional information by visiting our website at connecticare.com.

Electronic solutions/tools available to providers

Electronic solutions/tools available to ConnectiCare Providers include:

- Electronic claim submission options
- Electronic payment: EFT with ERA

- Availity Essentials portal: availity.com/providers

Electronic claim submission requirement

ConnectiCare strongly encourages participating Providers to submit claims electronically whenever possible. Electronic claim submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enabling claims to reach ConnectiCare faster

ConnectiCare offers the following electronic claim submission options:

- Submit claims directly to ConnectiCare via the Availity Essentials portal
- Submit claims to ConnectiCare through your EDI clearinghouse using Payer ID MLNCT.

While both options are accepted by ConnectiCare, submitting claims via the Availity Essentials portal (available to all Providers at no cost) offers a number of additional claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims.

Availity Essentials portal claim submission includes the ability to:

- Submit claims through direct data entry
- Add attachments to claims
- Submit claims through quick claims entry and saving templates
- Submit corrected claims
- Add attachments to corrected claims
- Add attachments to pending claims
- Easily and quickly void claims
- Check claim status
- Receive timely notification of a change in status for a particular claim
- Ability to save incomplete/un-submitted claims
- Create/manage claim templates

For additional information on EDI claim submission and paper claim submission please refer to the **Claims** section of this Provider Manual.

Electronic payment requirement

Participating Providers are strongly encouraged to enroll in EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services

give Providers the ability to reduce paperwork, utilize searchable ERAs and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment and Providers are not required to be in-network to enroll. ConnectiCare uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery processes.

ConnectiCare has partnered with ECHO Health, Inc., (ECHO), for payment delivery and 835 processing. On this platform, you may receive your payment via EFT/Automated Clearing House (ACH) or a physical check.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via check.

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the ConnectiCare payer ID. Please ensure that your practice management system is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal at providerpayments.com.

If you have any difficulty with the website or have additional questions, ECHO has a customer services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO customer service team at (888) 834-3511.

As a reminder, ConnectiCare's Payer ID is MLNCT.

Once your account is activated, you will begin receiving all payments through EFT and you will no longer receive a paper EOP (i.e., remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download and save historical and new ERAs with a two (2)-year lookback.

Availity Essentials portal

Providers and third-party billers can use the no-cost Availity Essentials portal to perform many functions online without the need to call or fax ConnectiCare. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
  - Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) claims with attached files
  - Correct/void claims
  - Add attachments to previously submitted claims
  - Check claim status
  - View ERA and EOP
  - Create and manage claims templates
  - Submit and manage claim disputes, including formal appeals or reconsideration requests, for finalized claims.

    - View, dispute, resolve claim overpayments.
- Prior authorization/service requests
    - Create and submit prior authorization/service requests
    - Check status of prior authorization/service requests
    - Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.
- Download forms and documents
- Send/receive secure messages to/from ConnectiCare
- Manage Overpayment invoices (Inquire, Dispute and Resolve)

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Provider Network Management portal: Enrollment Tool

The **Provider Network Management portal** is a secure, free tool used to manage Provider enrollment and credentialing requests. All credentialing requests for a Provider to join the network must be submitted electronically through the portal.

Available functions include:

- Adding practitioners to an existing group
- Submitting credentialing requests
- Tracking credentialing and participation status
- Providing additional or missing information for enrollment or credentialing
- Uploading provider rosters
- Adding new facility locations

Access

Office managers, administrative personnel, or Providers who need access to the portal for the first time must submit a registration request directly through the Provider Network Management portal.

Balance billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of ConnectiCare to the Provider. Balance billing a Member for covered services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Member rights and responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in ConnectiCare's Member materials (such as Member Handbooks).

For additional information please refer to the **Member Rights and Responsibilities** section of this Provider Manual.

Member information and marketing

Any written informational or marketing materials directed to ConnectiCare Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by ConnectiCare prior to use.

Please contact ConnectiCare Provider Relations representatives for information and review of proposed materials.

Member eligibility verification

Possession of a ConnectiCare Member ID Card does not guarantee Member eligibility or coverage. Providers should verify the eligibility of ConnectiCare Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and ConnectiCare places the responsibility for eligibility verification on the Provider of services.

Providers who contract with ConnectiCare may verify a Member's eligibility by checking the following:

- Availity Essentials portal: availity.com/providers
- ConnectiCare Provider Contact Center automated Interactive Voice Response (IVR) system at (800) 828-3407

For additional information, please refer to the **Eligibility and Grace Period** section of this Provider Manual.

Member cost sharing

Providers should verify the ConnectiCare Member's cost sharing prior to requiring the Member to pay copay, coinsurance, deductible or other cost sharing that may be applicable to the Member's specific benefit plan. Some plans have a total maximum cost sharing that frees the Member from any further out-of-pocket charges once reached (during that calendar year).

Health care services (utilization management and case management)

Providers are required to participate in and comply with ConnectiCare's utilization management and case management programs, including all policies and procedures regarding ConnectiCare's facility admission, prior authorization, medical necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with ConnectiCare in audits to identify, confirm and/or assess utilization levels of covered services.

For additional information please refer to the **Health Care Services** section of this Provider Manual.

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of emergency services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested and diagnosis for which the referral is being made.

Providers should direct ConnectiCare Members to health professionals, hospitals, laboratories and other facilities and Providers which are contracted and credentialed (if applicable) with ConnectiCare. In the case of urgent and emergency services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from ConnectiCare except in the case of emergency services.

For additional information please refer to the **Health Care Services** section of this Provider Manual.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to ConnectiCare.

Treatment alternatives and communication with Members

ConnectiCare endorses open Provider and Member communication regarding appropriate treatment alternatives and any follow-up care. ConnectiCare promotes open discussion between Providers and Members regarding medically necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Pharmacy program

Providers are required to adhere to ConnectiCare's drug formularies and prescription policies. For additional information please refer to the **Pharmacy** section of this Provider Manual.

Participation in quality improvement (QI) programs

Providers are expected to participate in ConnectiCare's QI programs and collaborate with ConnectiCare in conducting peer reviews and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to care standards

- Site and medical record-keeping practice reviews as applicable
- Delivery of patient care information

For additional information please refer to the **Quality** section of this Provider Manual.

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of ConnectiCare Members.

Confidentiality of Member health information and HIPAA transactions

ConnectiCare requires that Providers respect the privacy of ConnectiCare Members (including ConnectiCare Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member protected health information (PHI).

For additional information please refer to the **Compliance** section of this Provider Manual.

Participation in grievance and appeals programs

Providers are required to participate in ConnectiCare's grievance and appeals program and cooperate with ConnectiCare in identifying, processing and promptly resolving all Member complaints, grievances or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the **Complaints, Grievance and Appeals Process** section of this Provider Manual.

Participation in credentialing

Providers are required to participate in ConnectiCare's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by ConnectiCare and applicable accreditation, state and federal requirements. This includes providing prompt responses to ConnectiCare's requests for information related to the credentialing or re-credentialing process.

For additional information on ConnectiCare's credentialing program please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in ConnectiCare's Delegated Services Addendum. For additional information on ConnectiCare's delegation requirements and delegation oversight please refer to the **Delegation** section of this Provider Manual.

Primary care provider responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with ConnectiCare
- Triage appropriately
- Notify ConnectiCare of Members who may benefit from case management
- Participate in the development of are management treatment plans

4. Culturally and linguistically appropriate services

Background

ConnectiCare works to ensure all Members receive culturally and linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic and accessibility related needs of individuals served. ConnectiCare complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color and national origin, sex, age and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). ConnectiCare complies with applicable portions of the Americans with Disabilities Act of 1990. ConnectiCare also complies with all regulations for the foregoing. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, sexes, ages and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on culturally and linguistically appropriate services is available on the Availity Essentials portal (Go to Payer spaces, Resources Tab), from local ConnectiCare Provider Relations representatives and by calling ConnectiCare Provider Services at (800) 828-3407.

Non-discrimination in health care service delivery

ConnectiCare complies with Section 1557 of the ACA. As a Provider participating in ConnectiCare's Provider network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); state law and federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found at connecticare.com/legal/nondiscrimination.
3. You **MUST** post in a conspicuous location in your office a Tagline Document, that explains how to access non-English language services at no cost. A sample of

the Tagline Document that you will post can be found at connecticare.com/legal/nondiscrimination.

4. If a ConnectiCare Member is in need of accessibility-related services, you **MUST** provide reasonable accommodations for individuals with disabilities and appropriate auxiliary aids and services.
5. If a ConnectiCare Member is in need of language assistance services while at your office and you are a recipient of federal financial assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency (LEP). You can find resources on meeting your LEP obligations at Limited English Proficiency (LEP) | HHS.gov and Limited English Proficiency Resources for Effective Communication | HHS.gov.
6. If a ConnectiCare Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with ConnectiCare's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (866) 606-3889 (TTY/TDD: 711) Email: civil.rights@molinahealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/smartscreen/main Complaint Form: hhs.gov/ocr/complaints/index

If you or a ConnectiCare Member needs additional help or more information, call the Office of Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697.

Culturally and linguistically appropriate practices

ConnectiCare is committed to reducing health care disparities and improving health outcomes for all Members. Training employees, Providers and their staff and improving appropriateness and accessibility of services are the cornerstones of assessing, respecting and responding to a wide variety of cultural, linguistic and accessibility needs when providing health care services. ConnectiCare integrates culturally and linguistically appropriate practices training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that culturally and linguistically appropriate practices become a part of everyday thinking.

Provider and community training

ConnectiCare offers educational opportunities in culturally and linguistically appropriate practices and concepts for Providers and their staff. ConnectiCare conducts Provider training during Provider orientation with annual reinforcement training offered through

Provider Relations and/or online/web-based training modules. Web-based training modules can be found on the Availity Essentials portal.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials.
2. On-site culturally and linguistically appropriate practices training.
3. Online culturally and linguistically appropriate practices Provider training.
4. Integration of culturally and linguistically appropriate practices and concepts and non-discrimination of service delivery into Provider communications.

Integrated quality improvement

ConnectiCare ensures Member access to language services such as oral interpretation, American Sign Language (ASL), written materials in alternate formats, and written translation. ConnectiCare must also ensure access to programs, aids and services that are congruent with cultural norms. ConnectiCare supports Members with disabilities and assists Members with LEP.

ConnectiCare develops Member materials according to plain language guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on connecticare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including appeal and grievance forms, is also available in threshold languages on the ConnectiCare Member website.

Access to language services

Providers may request interpreters for Members who speak a language other than English, including American Sign Language, by calling ConnectiCare's Member Contact Center at (800) 251-7722. If ConnectiCare Member Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified interpreter.

ConnectiCare Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer ConnectiCare Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

All eligible Members with LEP are entitled to receive language services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP) or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are ConnectiCare Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility

regarding their process for obtaining such services. ConnectiCare is available to assist providers with locating these services if needed.

An individual with LEP is an individual whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

ConnectiCare Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964
- Be given access to care managers trained to work with individuals with cognitive impairments
- Be notified by the medical Provider that interpreter services, including American Sign Language, are available at no cost
- Be given reasonable accommodations, appropriate auxiliary aids and services
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf
    - Interpreters must ensure that this shared information is similarly safeguarded
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan

Interpreters include people who can speak the Member's primary language, assist with a disability or help the Member understand the information.

When ConnectiCare Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing and/or limited reading services are available.
- ConnectiCare is available to assist Providers with locating these services if needed:
    - Providers needing assistance finding onsite, video remote, or telephonic interpreter services may call ConnectiCare Member Services
    - Providers needing assistance obtaining written materials in preferred languages
    - Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD relay service at 711

- Providers with Members with limited vision may contact ConnectiCare for documents in large print, braille or audio version
- Providers with Members with LRP: ConnectiCare Member Contact Center representatives will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version

Documentation

As a contracted ConnectiCare Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by ConnectiCare.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of ConnectiCare's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost.

Members who are deaf or hard of hearing

TTY/TDD connection is accessible by dialing 711. This connection provides access to the ConnectiCare Member and Provider Contact Center, Quality, Health Care Services and all other health plan functions.

ConnectiCare strongly recommends that Provider offices make assistive listening devices available for Members who are deaf or hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

ConnectiCare will provide on-site or video service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made at least three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via the ConnectiCare Member Contact Center.

24-hour Nurse Advice Line

ConnectiCare provides nurse advice services for Members 24 hours per day, 7 days per week. The 24-hour Nurse Advice Line provides access to 24-hour interpretive services. Members may call the 24-hour Nurse Advice Line directly at (833) 957-0169 (TTY/TDD: 711). The 24-hour Nurse Advice Line telephone numbers are also printed on ConnectiCare Member ID cards.

Program and policy review guidelines

ConnectiCare conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership
  - Contracted Providers to assess gaps in network demographics
- Revalidate data at least annually
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report)
- Applicable national demographics and trends derived from publicly available sources
- Assessment of Provider Network and cultural responsiveness
- Collection of data and reporting for the Race/Ethnicity Description of Membership HEDIS® measure
- Collection of data and reporting for the Language Description of Membership HEDIS® measure
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found across the Plan's subpopulations
- Analysis of HEDIS® and Qualified Health Plan (QHP) Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services

5. Member rights and responsibilities

Providers must comply with the rights and responsibilities of ConnectiCare Members as outlined in the ConnectiCare Member Handbook and on the ConnectiCare website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Handbook can be found on the Member pages of ConnectiCare's website at connecticare.com/resources/access-plans.

The most current Member Rights and Responsibilities can be found ConnectiCare's website at connecticare.com/providers/billing-claims/eligibility-benefits.

State and federal law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact the ConnectiCare Provider Contact Center at (800) 828-3407, 8 a.m. to 6 p.m., ET, Monday through Friday. TTY/TDD users please call 711.

Second opinions

If a Member does not agree with their Provider's plan of care, they have the right to request a second opinion from another Provider. Members should call the ConnectiCare Member Contact Center to find out how to get a second opinion. Second opinions may require prior authorization.

6. Eligibility and grace period

Eligibility verification

Health Insurance Marketplace programs

Payment for services rendered is based on enrollment status and coverage selected. The contractual agreement between Providers and ConnectiCare places the responsibility for eligibility verification on the Provider of services.

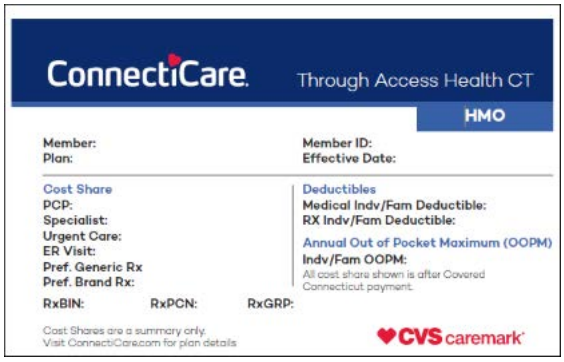
Eligibility listing for ConnectiCare Marketplace programs

Providers who contract with ConnectiCare may verify a Member's eligibility for specific services and/or confirm PCP assignment by checking the following:

- Availity Essentials portal: availity.com/providers
- ConnectiCare Provider Contact Center automated IVR system at (800) 828-3407

Possession of a ConnectiCare Member ID Card does not mean a recipient is eligible for Marketplace services. A Provider should verify a recipient's eligibility each time the recipient presents to their office for services. The verification sources can be used to verify a recipient's enrollment in a ConnectiCare Marketplace plan.

Member identification card sample - medical services



Members are reminded in their Agreement to present Member ID cards when requesting medical or pharmacy services. The ConnectiCare Member ID card can be a physical ID card or a digital ID card. It is the Provider's responsibility to ensure ConnectiCare Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an emergency medical condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Grace period

Definitions

Advance Premium Tax Credit (APTC) and/or Covered CT Member: A Member who receives advanced premium tax credits (premium subsidy) and/or Covered CT, which helps to offset the cost of monthly premiums for the Member.

Non-APTC Member: A Member who is not receiving any advanced premium tax credits or Covered CT and is therefore solely responsible for the payment of the full monthly premium amount.

Member: An individual, including any dependents, enrolled in ConnectiCare Marketplace. This term includes both APTC and/or Covered CT Members and Non-APTC Members.

Covered CT: Members enrolled in Covered CT have $0 member premium responsibility during their enrollment in Covered CT. The State of CT pays the “member portion” of the premium after the APTC is paid.

Summary

The Affordable Care Act (ACA) mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC and/or Covered CT Members who fail to pay their monthly premium by the due date. ConnectiCare Marketplace also offers a grace period in accordance with state law to Non-APTC Members who fail to pay their monthly premium by the due date. To qualify for a grace period, the Member must have paid at least one (1) full month’s premium within the benefit year. The grace period begins on the first day of the first month for which the Member’s premium has not been paid. The grace period is not a “rolling” period. Once the Member enters the grace period, they have until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace period timing

Non-APTC Members

Non-APTC Members are granted a 30-day grace period, during which they will not be able to access services covered under their benefit plan. During this grace period, claims will be paid. If the premium payment is not received, claims paid during the grace period will be reprocessed and denied for ineligibility. If the full past-due premium is not paid by the end of the grace period, the Non-APTC Member will be terminated effective the last day of the month prior to the beginning of the grace period.

Grace period for subscribers with APTCs or Covered CT

APTC and/or Covered CT Members are granted a three (3)-month grace period. During the first month of the grace period claims and authorizations will continue to be processed, including pharmacy claims. Services, authorization requests and claims may be denied or have certain restrictions during the second and third months of the grace period. If the APTC and/or Covered CT Member’s full past-due premium is not paid by the end of the third month of the grace period, the APTC and/or Covered CT Member will be retroactively terminated to the last day of the first month of the grace period.

Eligibility messages

When a Member is in the grace period, ConnectiCare will include an eligibility message on the Availity Essentials portal, interactive voice response (IVR) and in the call centers. This message will provide information about the Member's grace period status, including which month of the grace period that the Member is in (first month vs. second or third) as well as information about how authorizations and claims will be processed during this time. Providers should verify both the eligibility status AND any service messages when checking a Member's eligibility. For additional information about how authorizations and claims will be processed during this time, please refer to the Member Evidence of Coverage, or contact the ConnectiCare Member Contact Center at (800) 251-7722.

Notification

All Members will be notified upon entering the grace period. Additionally, when an APTC and/or Covered CT Member enters the grace period, their eligibility status becomes available on the Availity Essentials portal. The online eligibility notification will inform Providers as follows:

- Members who receive APTC and have entered the first month of the grace period will not have any service restrictions. Therefore, the message that Providers will see upon checking the Availity Essentials portal will read as follows: No Enrollment Restrictions.
- Providers will be notified and can check that the APTC and/or Covered CT Member entered the second or third month of the grace period.
- All Providers, specifically Providers who submitted claims for the APTC and/or Covered CT Member in the two (2) months prior to the start of the grace period, will be notified and able to check that the APTC and/or Covered CT Member entered the second or third months of the grace period.
- Providers will be notified and be able to check if the APTC and/or Covered CT Member is in the second or third months of the grace period before services are rendered and before submitting claims.

The online eligibility notification will advise Providers that services rendered during the second and third months of the grace period may be denied if the premium is not paid in full prior to the expiration of the third month of the grace period.

Prior Authorizations

All authorization requests will be reviewed based on medical necessity and will expire after 90 days. If a request for a prior authorization is made, the Provider will receive the following disclaimer:

> "Prior Authorization is a review of medical necessity and is not a guarantee of payment for services. Payment will be made in accordance with a determination of the member's eligibility on the date of service (for ConnectiCare Marketplace members, this includes grace period status), benefit limitations/exclusions, and other applicable standards during the

claim review, including the terms of any applicable provider agreement. If permitted under state law, ConnectiCare will pend claims for services provided to Marketplace members in months 2 & 3 of the Federally required grace period until such time as all outstanding premiums due are received or the grace period expires, whichever occurs first. For additional information on a Marketplace member's grace period status, please contact ConnectiCare."

APTC and/or Covered CT Members

If the APTC and/or Covered CT Member pays the full premium payment prior to the expiration of the three (3)-month grace period, Providers may then seek authorization for services. If the APTC and/or Covered CT Member received services during the second or third month of the grace period without prior authorization, the Provider may request a retro-authorization for those services already rendered. All authorization requests will be reviewed based on medical necessity.

Non-APTC Members

Authorization requests received during a Non-APTC Member's grace period will be processed according to medical necessity standards.

Claim processing

APTC and/or Covered CT Members

First month of grace period: clean claims received for services rendered during the first month of a grace period will be processed using ConnectiCare's standard processes in accordance with state and federal statutes and regulations and within established turnaround times.

Second/Third Month of Grace Period: clean claims received for services rendered during the second and third months of an APTC and/or Covered CT Member's grace period will be pending until the premium is paid in full. If the APTC and/or Covered CT Member is terminated for non-payment of the full premium prior to the end of the grace period, ConnectiCare will deny claims for services rendered in the second and third months of the grace period.

Pharmacy claims will be processed based on program drug utilization review and formulary edits; the APTC and/or Covered CT Member will be charged 100% of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-APTC Members

Clean claims received for services rendered during the grace period will be processed using ConnectiCare's standard processes, in accordance with state and federal statutes and regulations, and within established turnaround times.

7. Benefits and covered services

ConnectiCare covers the services described in the Summary of Benefits and Coverage and the Schedule of Benefits documentation for each ConnectiCare Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization please reference the prior authorization tools located on the ConnectiCare website and Availity Essentials portal. You may also contact the ConnectiCare Provider Contact Center at (800) 828-3407, 8 a.m. to 6 p.m., ET, Monday through Friday, excluding state and federal holidays.

Verification of benefits

Detailed information about benefits and services can be found in the Schedule of Benefits made available to ConnectiCare Marketplace Members via the ConnectiCare Member portal. Providers can access Schedule of Benefits documents via the Availity Essentials portal.

Member cost sharing

Cost sharing is money that Members pay out of pocket for covered services according to the plan design they have signed up for. Members may be required to meet a deductible for some covered services. A Deductible is money a Member must pay out of pocket for a covered service before the plan starts paying for that service. Not all services have a deductible requirement. Besides the deductible, Members will have cost sharing for most covered services. Depending on the plan design, the cost sharing will be a flat dollar amount (copayment) or percentage of the amount the Provider is being paid (coinsurance) for covered services they are receiving. The cost sharing amount that Members will be required to pay for each type of covered service is summarized on the Schedule of Benefits. Information for some services is found on the ConnectiCare Member ID card. Cost sharing applies to all covered services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). State or federal laws that apply to Marketplace may reduce or eliminate cost sharing for other services.

A Member pays the lesser of the cost sharing amount or billed charges.

It is the Provider's responsibility to collect the copayment and other Member cost sharing from the Member to receive full reimbursement for a service. The amount of the copayment and other cost sharing will be deducted from the ConnectiCare payment for all claims involving cost sharing.

Formulary exception request Process

A request for a formulary exception must be submitted using the same forms and procedures as submitting a prescription drug prior authorization request. The information submitted should show the Member factors and medical reasons why formulary drugs are not right for them. A copy of the Drug Formulary and Guide is found at connecticare.com.

Formulary exceptions can be designated as urgent to expedite the review process and timeframe:

- Expedited Exception Requests are for urgent circumstances that may seriously jeopardize life, health or ability to regain maximum function or for undergoing current treatment using the requested drug. Drug samples will not be considered as current treatment.
- Standard Exception Requests are for circumstances that do not meet the definition of urgent.

The Member and/or Member's representative and the prescribing Provider will be notified of ConnectiCare 's decision no later than:

- 24 hours following receipt of request for Expedited Exception Request.
- 72 hours following receipt of request for Standard Exception Request.

If the initial request is denied, an external review may be requested. The Member and/or Member's representative and the prescribing Provider will be notified of the external review decision no later than:

- 24 hours following receipt of the request for external review of the Expedited Exception Request.
- 72 hours following receipt of the request for external review of the Standard Exception Request.

Injectable and infusion services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor, designated by ConnectiCare. More information about our prior authorization process, including a link to the Prior Authorization Request Form, is available in the **Pharmacy** section of this Provider Manual.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered.

Access to behavioral health services

ConnectiCare's vendor, Optum Behavioral Health, coordinates and manages behavioral health and substance abuse services for Members. Behavioral health services are a direct access benefit and are available with no referral required. Health care professionals may assist Members in finding a behavioral health Provider or Members may contact Optum at (888) 946-4658. ConnectiCare's 24-hour Nurse Advice Line is available 24 hours a day, 7 days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential.

Additional information regarding covered services and any limitations can be obtained in the benefit information linked above or by contacting ConnectiCare. If inpatient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation and inpatient Member cost sharing will apply.

Emergency mental health or substance use disorder services

Members are directed to call 988, 911 or go to the nearest emergency room if they are in need of emergency mental health or substance use services. Examples of emergency mental health or substance use problems are:

- Danger to self or others
- Not being able to carry out daily activities
- Things that will likely cause death or serious bodily harm

Emergency services when out of the service area

Members having a health emergency who cannot get to a ConnectiCare approved Provider are directed to do the following:

- Go to the nearest emergency room
- Call the number on the ConnectiCare Member ID card
- Call Member's PCP and follow-up within 24 to 48 hours

For out-of-area emergency care, out-of-network Providers are directed to call the ConnectiCare contact number on the back of the ConnectiCare Member ID card for additional benefit information and may be asked to transfer Members to an in-network facility when the Member is stable.

Emergency transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

For emergency ground and air ambulance, for both in-network and out-of-network Providers, the Member is responsible only for the plan's in-network cost-sharing amount and Providers are prohibited by state and federal law from balance billing the Member.

Preventive care

Preventive care guidelines are located on the ConnectiCare website at connecticare.com.

24-hour Nurse Advice Line

Members may call the 24-hour Nurse Advice Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week, 365 days a year.

ConnectiCare is committed to helping our Members:

- Prudently use the services of your office
- Understand how to handle routine health problems at home

- Avoid making non-emergent visits to the emergency room

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the 24-hour Nurse Advice Line. The 24-hour Nurse Advice Line may refer back to the PCP, a specialist, 911 or the emergency room. By educating patients, it reduces costs and over utilization on the health care system.

Telehealth and telemedicine services

ConnectiCare Members may obtain medical covered services by participating Providers, through the use of telehealth and telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a participating Provider
- Members have the option of receiving telehealth services from participating Providers, who offer and have the capability of providing these services with associated plan cost sharing
- Services are a method of accessing covered services and not a separate benefit
- Services are not permitted when the Member and participating Provider are in the same physical location
- Member cost sharing may apply based on the applicable Schedule of Benefits
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines
- Rendering Provider must comply with applicable federal and state guidelines for telehealth service delivery

For additional information on telehealth and telemedicine services claims and billing please refer to the **Claims** section of this Provider Manual.

8. Health care services

Introduction

Health care services (HCS) is comprised of utilization management (UM) and case management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. ConnectiCare provides CM services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the ConnectiCare UM program include pre-service authorization review, inpatient authorization management that includes admission and concurrent medical necessity review and restrictions on the use of out-of-network or non-participating Providers.

Utilization management (UM)

ConnectiCare ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. ConnectiCare's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence a Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care
- Evaluating the medical necessity and efficiency of health care services across the continuum of care
- Defining the review criteria, information sources and processes that are used to review and approve the provision of items and services, including prescription drugs
- Coordinating, directing and monitoring the quality and cost-effectiveness of health care resource utilization
- Implementing comprehensive processes to monitor and control the utilization of health care resources
- Ensuring services are available in a timely manner, in appropriate settings and are planned, individualized and measured for effectiveness
- Reviewing processes to ensure care is safe and accessible
- Ensuring qualified health care professionals perform all components of the UM processes
- Ensuring that UM decision-making tools are appropriately applied in determining medical necessity decision.

Key functions of the UM program

All prior authorizations are based on a specific standardized list of services. The key functions of the UM program are listed below:

- **Eligibility and oversight**

- Eligibility verification
- Benefit administration and interpretation
- Verification that authorized care correlates to Member's medical necessity need(s) and benefit plan
- Verifying of current physician/hospital contract status

- **Resource management**
  - Prior authorization and referral management
  - Admission and inpatient review
  - Referrals for discharge planning and care transitions
  - Staff education on consistent application of UM functions
- **Quality management**
  - Evaluate satisfaction of the UM program using Member and Provider input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources
  - Quality oversight
  - Monitor for adherence to Center for Medicare & Medicaid (CMS), NCQA, state and health plan UM standards

For more information about ConnectiCare's UM program or to obtain a copy of the HCS program description clinical criteria used for decision making and how to contact a UM reviewer, access the ConnectiCare website or contact the UM department.

Medical groups/IPAs and delegated entities who assume responsibility for UM must adhere to ConnectiCare's UM Policies. Their programs, policies and supporting documentation are reviewed by ConnectiCare at least annually.

UM decisions

An organizational determination is any decision made by ConnectiCare or the delegated medical group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination).
- Determination to delay, modify or deny authorization or payment of request (adverse determination).

ConnectiCare follows a hierarchy of medical necessity decision-making with federal and state regulations taking precedence. ConnectiCare covers all services and items required by federal and state regulations.

Board-certified licensed reviewers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal and state regulatory requirements and NCQA standards.

Requests for authorization not meeting medical necessity criteria are reviewed by a designated ConnectiCare Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified

addiction medicine specialist as appropriate may determine to delay, modify or deny authorization of services to a Member.

Providers can contact ConnectiCare's Healthcare Services department at (800) 562-6833 to obtain ConnectiCare's UM Criteria.

Where applicable, ConnectiCare clinical policies can be found on the public website at molinaclinicalpolicy.com. Please note that ConnectiCare follows state-specific criteria, if available, before applying ConnectiCare-specific criteria.

Medical necessity

"**Medically Necessary**" or "**Medical Necessity**" means health care services or supplies required for diagnosing or treating an illness, injury, condition, disease, or its symptoms, and that meet accepted medical standards.

This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. ConnectiCare must deem those services to be:

1. In accordance with generally accepted standards of medical practice.
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease.
3. Not primarily for the convenience of the patient, physician or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, by itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

ConnectiCare has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite for Guideline Transparency, ConnectiCare can share clinical indications with Providers. The tool operates as a secure extension of ConnectiCare's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency — Delivers medical determination transparency
- Access — Clinical evidence that payers use to support member care decisions

- Security — Ensures easy and flexible access via secure web access

MCG Cite for Guideline Transparency does not affect the process for notifying ConnectiCare of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

ConnectiCare has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 days per week. This method of submission is strongly encouraged as your primary submission route. ConnectiCare will also be rolling out additional services throughout the year. Clinical information submitted with the prior authorization will be reviewed by ConnectiCare. This system will provide quicker and more efficient processing of your authorization request and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each prior authorization request and sending it directly to ConnectiCare, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares ConnectiCare's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include but are not limited to MRIs, CTs and PET scans. To see the full list of imaging codes that require prior authorization, refer to the Prior Authorization Code LookUp Tool at connecticare.com.

Medical necessity review

ConnectiCare only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, ConnectiCare uses nationally recognized evidence-based guidelines, third-party guidelines, CMS guidelines, state guidelines, ConnectiCare clinical policies, guidelines from recognized professional societies and advice from authoritative review articles and textbooks.

Levels of administrative and clinical review

The ConnectiCare review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity adverse determination are reviewed by a health care professional at ConnectiCare (medical director, pharmacy director or appropriately licensed health care professional).

ConnectiCare's Provider training includes information on the UM processes and Authorization requirements.

Clinical information

ConnectiCare requires copies of clinical information be submitted for documentation. Clinical information includes but is not limited to physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. ConnectiCare does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Prior authorization

ConnectiCare requires prior authorization for specified services as long as the requirement complies with federal or state regulations and the Provider Agreement with ConnectiCare. A list of services that require prior authorization is available in narrative form, along with a more detailed list by Current Procedural Terminology (CPT) and Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes. To see the full list of codes that require prior authorization, please refer to the Prior Authorization LookUp Tool at connecticare.com. ConnectiCare prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate and are posted on the ConnectiCare website at ConnectiCare.com.

CPT® is a registered trademark of the American Medical Association

The prior authorization request must include the following information:

- Member demographic information (name, date of birth, ConnectiCare Member ID number)
- Provider demographic information (referring Provider and referred to Provider/facility) including address and NPI number)
- Member diagnosis and International Classification of Diseases 10th Revision (ICD-10) codes
- Requested service/procedure, including all appropriate CPT and HCPCS codes
- Location where service will be performed
- Clinical information sufficient to document the medical necessity of the requested service is required including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data)
    - Requested length of stay (for inpatient requests)
    - Rationale for expedited processing

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the prior authorization requirements. Obtaining authorization does not guarantee payment. ConnectiCare retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost effective setting of care. ConnectiCare does not retroactively authorize services that require prior authorization.

ConnectiCare follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

ConnectiCare makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

ConnectiCare will make an organizational determination as promptly as the Member's health requires and no later than contractual and regulatory requirements. Expedited timeframes are followed when the Provider indicates or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health.

Providers who request prior authorization for services and/or procedures may request to review the criteria used to make the final decision. A ConnectiCare Medical Director is available to discuss medical necessity decisions with the requesting Provider at (800) 562-6833 during business hours.

Upon approval, the requestor will receive an authorization number. The number will be provided via the Availity Essentials portal. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider.

Peer-to-peer review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within a two (2)-week period from the notification.

A "peer" is considered the Member's or Provider's clinical representative (licensed medical professional). Contracted external parties, administrators or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed but the discussion should be performed by a peer.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ConnectiCare Member ID number
- Authorization ID number
- Requesting Provider name, contact number and best times to call

If a medical director is not immediately available, the call will be returned within two (2) business days. Every effort will be made to return calls as expeditiously as possible.

Requesting prior authorization

Notwithstanding any provision in the Provider Agreement with ConnectiCare that requires Providers to obtain a prior authorization directly from ConnectiCare, ConnectiCare may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the connecticare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix

Availity Essentials portal: Participating Providers must use the Availity Essentials portal for prior authorization submissions. All prior authorization submissions must include supporting clinical documentation to ensure timely and accurate review. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

- Create and submit prior authorization requests
- Check status of prior authorization requests
- Receive notification of change in status of prior authorization requests
- Attach medical documentation required for timely medical review and decision-making
- Receive notification of authorization decisions
- Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for PA requests submitted via the Availity Essentials portal.

Prior authorization requests for Advanced Imaging and Transplants can also be made by calling (855) 714-2415.

Evolent: oncology

ConnectiCare collaborates with Evolent (formerly known as New Century Health) to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for ConnectiCare adult Members ages 18 and over.

All out-of-network Servicing Provider PA requests and PA requests for ConnectiCare Members under the age of 18 will be reviewed by ConnectiCare.

Please consult the PA Lookup Tool for further guidance on where to submit professional services PA requests.

For inpatient service requests, once approved by Evolent, the inpatient status will be reviewed by ConnectiCare upon notification of the admission. The inpatient admission and length of stay will be determined by Inpatient Utilization Management (Concurrent Review) at the time of hospitalization. Providers are to follow ConnectiCare's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time.

Medical oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0, Z41.8

Infused, injectable and oral* chemotherapy, hormonal therapeutic treatment, supportive agents, and symptom management medications.

**Pharmacy benefit single oral agent requests are out of scope for Evolent and pre-authorization must be obtained from ConnectiCare or applicable Pharmacy Benefits Manager (PBM). For Marketplace Members, Pharmacy benefits oral agents submitted in a request combined with infused/injectable cancer agents will be reviewed by Evolent for preauthorization.*

Radiation oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0, Z41.8

- Brachytherapy
- Conformal
- IMRT (Intensity-modulated radiation therapy)
- SBRT (Stereotactic Body Radiation Therapy)
- IGRT (Image-guided radiation therapy)
- 2D, 3D (2 or 3 dimensional)
- SRS (Stereotactic radiosurgery)
- Radiopharmaceuticals
    - Proton and Neutron Beam Therapy

CAR-T

For inpatient CAR-T service requests, the inpatient status will be approved when medical necessity criteria is met, simultaneously with the approval of the CAR-T professional service(s) being reviewed.

The inpatient admission length of stay (where CAR-T is in scope) will be determined by Inpatient Utilization Management (Concurrent Review) at the time of any needed hospitalization. Providers are to follow ConnectiCare's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time. If other services are being performed during the inpatient stay that are unrelated to the CAR-T procedures, a separate authorization will need to be completed through ConnectiCare's standard prior authorization process for medical necessity determination.

PA request submission

The requesting in-network Provider must complete a PA request using one of the following methods:

- For Providers' convenience, logging into the Evolent Provider web portal is the preferred submission method: my.newcenturyhealth.com
  - Evolent's Provider web portal functionality offers instant approvals for PA requests
- Evolent Tel: (888) 999-7713
  - Option 2 Medical Oncology
  - Option 3 Radiation Oncology

Providers should call the Evolent Network Operations department at (888) 999--7713, Option 6, with questions or for assistance with access/training on the Evolent Provider web portal.

Peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

ProgenyHealth: NICU admission and concurrent review

ConnectiCare collaborates with ProgenyHealth for neonatal care management services provided to premature and medically complex newborns in the Neonatal Intensive Care Unit (NICU).

All NICU UM functions including initial admissions, continued stay requests, discharge planning and all readmissions up to 60 days post-discharge of the initial NICU discharge

will be managed by ProgenyHealth. Providers must submit NICU authorization requests and clinical documentation supporting the NICU stay to ProgenyHealth directly.

- Phone: (888) 832-2006
- UM Email: molinamarketplaceum@progenyhealth.com
- CM Email: molinamarketplacecm@progenyhealth.com
- Website: progenyhealth.com

For all infants born and/or admitted to the NICU on/or after 01/01/2026, NICU Notification of Admission must be faxed directly to ProgenyHealth at (877) 847-1708. The following information must be included:

- Mother's Name, Date of Birth, Member ID
- Infant Name (if known) and Member ID (if known)
- Attending Physician NPI number
- Facility NPI number

Peer-to-peer review

Peer-to-peer review may be requested with a ProgenyHealth Medical Director by calling (888) 832-2006 and following the Physician Advisor's prompts and directions.

If peer-to-peer is declined or if the denial determination is upheld, Providers would follow the ConnectiCare Marketplace appeal process if not in agreement with the denial determination.

Transfers and readmissions

ProgenyHealth will manage infants transferred from the NICU to another acute care facility under the guidance of ConnectiCare Marketplace current rules for higher, lateral, and lower-level care transfers.

ProgenyHealth will manage emergent readmissions for all infants managed by ProgenyHealth for their initial NICU admission if readmitted within the first 60 days after the initial NICU discharge date.

UM cases

Infants receiving NICU level of care who were admitted prior to 01/01/2026, and remain inpatient on or after 01/01/2026, will be transitioned to ProgenyHealth for continued medical management.

All concurrent stay reviews and discharge summaries should be faxed directly to ProgenyHealth.

CM program review

A dedicated ProgenyHealth case manager will provide support and education.

Following notification of NICU admission, ProgenyHealth collaborates with caregivers for early inpatient engagement to evaluate Social Determinants of Health and barriers to safe discharge home.

ProgenyHealth case managers will continue to follow Members for 60 days from the initial NICU discharge date.

ProgenyHealth case managers, social workers, and care coordinators will assist Members with identifying support and utilizing national and local community resources:

- Identifying PCP
- Behavioral health support
- Lactation services/obtaining a breast pump
- Transportation resources

ProgenyHealth will collaborate with facility CM for infants with anticipated discharge needs, complex medical care, or considerable social situations.

Open communication about treatment

ConnectiCare prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with and act as an advocate for their patients. ConnectiCare requires provisions within the Provider Agreement with ConnectiCare that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

ConnectiCare and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans or other coverage arrangements.

Delegated Utilization Management functions

ConnectiCare may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to perform the delegated activities and maintain specific delegation criteria in compliance with all current ConnectiCare policies and regulatory and certification requirements. For additional information about delegated UM functions and the oversight of such delegation, please refer to the **Delegation** section of this Provider Manual.

Communication and availability to Members and Providers

HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (800) 562-6833, Monday through Friday (except for state and federal holidays) from 9 a.m. to 5 p.m., ET. All staff members identify themselves by providing their first name, job title and organization.

TTY/TDD services are available for Members who are deaf, hard of hearing or speech impaired. Language assistance is also always available for Members.

Providers must utilize the Availity Essentials portal for UM access.

ConnectiCare's 24-hour Nurse Advice Line is available to Members 24 hours a day, 7 days a week at (833) 957-0169; TTY/TDD: 711. ConnectiCare's 24-hour Nurse Advice Line may handle urgent and emergent after-hours UM calls.

Emergency services

Emergency services means: (A) a medical screening examination that is within the capability of a hospital emergency department, including ancillary services routinely available to such department to evaluate such condition, and (B) such further medical examinations and treatment required to stabilize such individual that are within the capability of the hospital staff and facilities.

Emergency medical condition or emergency means: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine, acting reasonably, would have believed that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency services rendered to the Member do not require prior authorization from ConnectiCare.

Emergency services are covered on a 24 hour basis without the need for prior authorization for all Members experiencing an emergency medical condition.

Post-stabilization care services are covered services that are:

1. Related to an emergency medical condition
2. Provided after the Member is stabilized
3. Provided to maintain the stabilized condition or under certain circumstances, to improve or resolve the Member's condition

Providers requesting an inpatient admission as a post-stabilization service must request this type of service by contacting ConnectiCare at (800) 562-6833.

Inpatient admission requests (not including post-stabilization requests) received via the Availity Essentials portal will be processed within standard inpatient regulatory and contractual time frames.

ConnectiCare also provides Members with a 24-hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area, ConnectiCare contracts with vendors that provide 24-hour emergency services for ambulance and hospitals. An out-of-network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to an available participating facility. Services provided after stabilization in a non-participating facility may not be covered and the Member may be responsible for payment. Member payments to the non-participating facility will not apply to the Member's deductible or annual out-of-pocket maximum.

Care managers will contact ConnectiCare Members identified as high utilizers of emergency services and provide outreach, assessment of utilization of emergency services and education to appropriate care and services to meet medical needs.

Inpatient management

Planned admissions

ConnectiCare requires prior authorization for all elective inpatient procedures to any facility. Facilities are required to notify ConnectiCare within 24 hours or by the following business day once an admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent inpatient admissions

ConnectiCare requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC) and initiate concurrent review and discharge planning. ConnectiCare requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the inpatient admission may result in a denial of authorization for the inpatient stay.

Inpatient at time of termination of coverage

If coverage with ConnectiCare terminates during a hospital stay, the services received after the Member's termination date are not covered services.

Inpatient/concurrent review

ConnectiCare performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. ConnectiCare will request updated clinical records from inpatient facilities at regular intervals during a member's inpatient stay. ConnectiCare requires that requested clinical information updates be received by ConnectiCare from the inpatient facility within 24 hours of the request.

Failure to provide timely clinical information updates may result in a denial of authorization for the remainder of the inpatient stay dependent on the Provider Agreement with ConnectiCare terms and agreements.

ConnectiCare will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care and the observation level of care has failed. Upon discharge the Provider must provide ConnectiCare with a copy of the Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions and disposition.

Inpatient status determinations

ConnectiCare's UM staff follow federal and state guidelines along with evidence based criteria to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and medical necessity requirements (refer to the **Medical Necessity Review** subsection of this Provider Manual).

Discharge planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of ConnectiCare's QI program to ensure that ConnectiCare Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

ConnectiCare will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 30 days of discharge and it is determined that the subsequent readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
  - Premature or inadequate discharge from the same hospital
  - Issues with transition or coordination of care from the initial admission
  - For an acute medical complication plausibly related to care that occurred during the initial admission
- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions associated with major or metastatic malignancies, multiple trauma and burns
  - Neonatal and obstetrical readmissions
  - Initial admissions with a discharge status of “left against medical advice” because the intended care was not completed
  - Behavioral health readmissions
  - Transplant-related readmissions

Post-service review

Failure to obtain prior authorization when required may result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that the patient was a ConnectiCare Member or there was a ConnectiCare error. In those cases, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical necessity.

Specific federal or state requirements or the Provider Agreement with ConnectiCare that prohibit administrative denials supersede this policy.

Affirmative statement about incentives

All medical decisions are coordinated and rendered by qualified practitioners and licensed staff unhindered by fiscal or administrative concerns. ConnectiCare and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

ConnectiCare requires that all utilization-related decisions regarding Member coverage and/or services are based solely on the appropriateness of care and the existence of coverage. ConnectiCare does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. ConnectiCare does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-network providers and services

ConnectiCare maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to ConnectiCare Members. ConnectiCare requires Members to receive medical care within the participating, contracted network of Providers unless it is for emergency

services as defined by federal law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by ConnectiCare. Non-network Providers may provide emergency services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by federal or state laws or regulations.

Avoiding conflict of interest

The HCS department affirms its decision-making is based on the appropriateness of care and service and the existence of benefit coverage.

ConnectiCare does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, ConnectiCare never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. ConnectiCare also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of care and services

ConnectiCare HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for ConnectiCare's Integrated Care Management (ICM) program via assessment or referral such as self-referral, caregiver or Provider referrals. In addition, the coordination of care process assists ConnectiCare Members, as necessary, in transitioning to other care when benefits end.

ConnectiCare staff provide an integrated approach to addressing care needs by assisting Members with the identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, identifying best practices or new and innovative approaches to care. Care coordination by ConnectiCare staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of care and transition of Members

It is ConnectiCare's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to the course of treatment, medical treatment, etc., to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to 90 days or longer if necessary, for a safe transfer to another Provider as determined by ConnectiCare or its delegated medical group/IPA

- High risk of second or third-trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary, for a safe transfer

For additional information regarding continuity of care and transition of Members please contact ConnectiCare at (800) 828-3407.

Continuity and coordination of Provider communication

ConnectiCare stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of suspected abuse and/or neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themself or unable to protect themself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the Law as mandated reporters are:

- Physicians, dentists, interns, residents or nurses
- Public or private school employees or child care givers
- Psychologists, social workers, family protection workers or family protection specialists
- Attorneys, ministers or law enforcement officers

Suspected abuse and/or neglect should be reported as follows:

Child Abuse

Connecticut State Department of Children and Families (800) 842-2288

Adult Abuse

Connecticut State Department of Social Services
Protective Services for the Elderly

- **By Phone:** Toll-free line: **(888) 385-4225.**
  - Staff are available to receive calls between 8:00 a.m. and 4:30 p.m., Monday through Friday.
  - After business hours or on weekends or state holidays: call the Infoline at **2-1-1**
  - Outside of Connecticut: call the Infoline 24/7 at **(800) 203-1234**
- **By Form:** Complete the Report Form (W-675)

    - Email to psereferrals.dss@ct.gov
    - Fax to (860) 424-5091
    - Mail to DSS/PSE, 55 Farmington Avenue, Hartford, CT 06105
- **Online:** Complete an online referral

ConnectiCare's HCS teams will work with PCPs and medical groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/medical group/IPA, other delegated entities or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

ConnectiCare will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures were taken and follow up on safety issues. ConnectiCare will track, analyze and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper state agency.

PCP responsibilities in case management referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with the Member's Individualized Care Plan (ICP), interdisciplinary care team (ICT) updates and information regarding the Member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care manager responsibilities

The care manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from the Member's ICT as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals and a statement of expected outcomes. Jointly, the care manager and the Member are responsible for implementing the plan of care. Additionally, the care manager:

- Assesses the Member to determine if the Member's needs warrant case management
- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as the Member's needs warrant
- Serves as a coordinator and resource to the Member, their representative and ICT participants throughout the implementation of the ICP and revises the plan as suggested and needed

- Coordinates appropriate education and encourages the Member's role in self-management
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program

Health management

The tools and services described here are educational support for ConnectiCare Members and may be changed at any time as necessary to meet the needs of ConnectiCare Members. Level 1 Members can be engaged in the program for up to 90 days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Case management (health management)

ConnectiCare offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition-specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk Assessments (HRA) and identification and stratification. You can also directly refer Members who may benefit from these program offerings by contacting ConnectiCare. Members can request to be enrolled or disenrolled in these programs at any time.

The chronic conditions programs include:

- Asthma
- Depression
- Diabetes
- COPD
- Heart Failure
- Hypertension

ConnectiCare healthy lifestyle programs include:

- Weight Management
- Tobacco Cessation
- Nutrition consult

For more information about these programs, please call (833) 269-7830 (main line) or (866) 472-9483 (health lifestyle programs), TTY/TDD: 711 or fax at (800) 642-3691.

Maternity screening and high-risk obstetrics

ConnectiCare offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for Members with identified high risk pregnancies to assure best outcomes for Members and their newborns during pregnancy, delivery and

through their sixth week post-delivery. Pregnant Member outreach, screening, education and case management are initiated by Provider notification to ConnectiCare, Member self-referral and internal ConnectiCare notification processes. Providers can notify ConnectiCare of pregnant/high-risk pregnant Members via Pregnancy Notification Report Forms.

Member newsletters

Member newsletters are posted on the connecticare.com website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member health education materials

Members can access our easy-to-read evidence-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression and other relevant health topics identified during our engagement with Members. Materials are available through the ConnectiCare Member portal, direct mail as requested, email and the MyConnectiCare mobile app.

Program eligibility criteria and referral source

Health management (HM) programs are designed for ConnectiCare Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach or other materials to access information on their condition. Members can contact the ConnectiCare Member Contact Center at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy claims data for all classifications of medications.
- Encounter Data or paid claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- External referrals from Provider(s), caregivers or community-based organizations.
- Internal ConnectiCare referrals from the 24-hour Nurse Advice Line, medication management or utilization management.
- Member self-referral due to general plan promotion of programs through Member newsletter or other Member communications.

Provider participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs.
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on health management programs is available from your local ConnectiCare Healthcare Services department.

Primary care providers

ConnectiCare provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by ConnectiCare. ConnectiCare's Members may select or change their PCP by contacting the ConnectiCare Member Contact Center.

Specialty providers

ConnectiCare maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women's health specialists for routine and preventive health without a referral for services.

ConnectiCare will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the ConnectiCare UM department. Referrals to specialty care outside the network require prior authorization from ConnectiCare.

Case management (CM)

ConnectiCare provides a comprehensive ICM program to all Members who meet the criteria for services. The ICM program focuses on coordinating the care, services and resources needed by Members throughout the continuum of care. ConnectiCare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The ConnectiCare care managers may be licensed professionals and are educated, trained and experienced in ConnectiCare's ICM program. The ICM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency and to produce optimal outcomes. The ICM program is individualized to

accommodate a Member's needs with collaboration and input from the Member's PCP. The ConnectiCare care manager will complete an assessment with the Member upon engagement after identification for ICM enrollment, assist with the arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services and preventive services. The ConnectiCare care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of the ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to case management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP, specialty care Provider, themselves, caregiver, discharge planner or ConnectiCare Healthcare Services to the ICM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, ancillary Providers, the local health department or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care and social data about the Member being referred.

Members with the following conditions may qualify for case management and should be referred to the ConnectiCare ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g., neoplasm organ/tissue transplants, End Stage Renal Disease).
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.).
- Preterm infants.
- High-technology home care requiring more than two (2) weeks of treatment.
- Member accessing emergency department services inappropriately.
- Children with Special Health Care Needs

Referrals to the ICM program may be made by contacting ConnectiCare at:

Phone: (800) 828-3407

9. Behavioral health

ConnectiCare's vendor, Optum Behavioral Health, coordinates and manages behavioral health and substance abuse services for Members. Optum Behavioral Health has a Help Line that Members and Providers can access by calling (888) 946-4658. Standard hours of operation are 7 a.m. to 7 p.m., CST. When Members call this number at any time there is an IVR prompt that asks if they have concerns about their own or someone else's safety. If the Member answers YES, they are routed directly to a crisis team 24/7.

For Clinical Assistance, Providers can contact Optum Behavioral Health at (800) 349-5365 from 7 a.m. to 7 p.m., CST. For higher level of care auth requests ONLY, Providers can call this number 24/7.

For additional information please refer to Optum's website at providerexpress.com.

Claims address:

Optum Behavioral Health
PO Box 30757
Salt Lake City, UT 84130-0757

10. Quality

Maintaining quality improvement processes and programs

ConnectiCare works with Members and Providers to maintain a comprehensive Quality Improvement (QI) program. You can contact the ConnectiCare Quality department at (800) 828-3407.

The address for mail requests is:

ConnectiCare
Quality Department
175 Scott Swamp Road
PO Box 4050
Farmington, CT 06034-4050

This Provider Manual contains excerpts from the ConnectiCare QI program. For a complete copy of ConnectiCare's QI program, you can contact your ConnectiCare Provider Relations representative or call the telephone number above to receive a written copy.

ConnectiCare has established a QI program that complies with regulatory requirements and accreditation standards. The QI program provides structure and outlines specific activities designed to improve the care, service and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure and responsibilities.

ConnectiCare does not delegate Quality improvement activities to medical groups/IPAs. However, ConnectiCare requires contracted medical groups/IPAs to comply with the following core elements and standards of care. ConnectiCare medical groups/IPAs:

- Have a quality improvement program in place
- Comply with and participate in ConnectiCare's QI program including reporting of access and availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations
- Cooperate with ConnectiCare's quality improvement activities that are designed to improve quality of care and services and Member experience
- Allow ConnectiCare to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service and access and availability
- Allow access to ConnectiCare Quality personnel for site and medical record review processes.

Patient safety program

ConnectiCare's Patient Safety Program identifies appropriate safety projects and error avoidance for ConnectiCare Members in collaboration with their PCPs. ConnectiCare continues to support personal health practices for our Members through our safety program, pharmaceutical management and case management/health management programs and education. ConnectiCare monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA) and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of care

ConnectiCare has established a systematic process to identify, investigate, review and report any quality of care, adverse event/never event, critical incident (as applicable) and/or service issues affecting Member care. ConnectiCare will research, resolve, track and trend issues. Confirmed adverse events/never events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

ConnectiCare is not required to pay for inpatient care related to "never events."

Medical records

ConnectiCare requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's medical record. PCPs should maintain the following medical record components that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records
- Medical record content and documentation standards, including preventive health care
- Storage maintenance and disposal processes
- Process for archiving medical records and implementing improvement activities

Medical record-keeping practices

Below is a list of the minimum items that are necessary in the maintenance of the Member medical records:

- Each patient has a separate medical record.

- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when the thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language and sexual orientation and gender identity.
- Storage maintenance for the determined timeline and disposal are managed per record management processes.
- Process is in place for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Content

Providers must remain consistent in their practices with ConnectiCare's medical record documentation guidelines. Medical records are maintained and should include, but not limited to the following information. All medical records should contain:

- The patient's name or ID number each page in the record contains
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers and emergency contact
- Legible signatures and credentials of the Provider and other staff members within a paper chart
- A list of all Providers who participate in the Member's care
- Information about services that are delivered by these Providers
- A problem list that describes the Member's medical and behavioral health conditions
- Presenting complaints, diagnoses and treatment plans, including follow-up visits and referrals to other Providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Medication reconciliation within 30 days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed
- Allergies and adverse reactions (or notation that none are known)
- Documentation that shows advanced directives, power of attorney and living will have been discussed with Member and a copy of advance directives when in place
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors
- Treatment plans that are consistent with diagnosis
- A working diagnosis that is recorded with the clinical findings
- Pertinent history for the presenting problem
- Pertinent physical exam for the presenting problem
- Lab and other diagnostic tests that are ordered as appropriate by the Provider

- Clear and thorough progress notes that state the intent for all ordered services and treatments
- Notations regarding follow-up care, calls or visits that include the specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate
- Notes from consultants as applicable
- Up-to-date immunization records and documentation of appropriate history
- All staff and Provider notes are signed physically or electronically with either name or initials
- All entries are dated
- All abnormal lab/imaging results show explicit follow up plan(s)
- All ancillary services reports
- Documentation of all emergency care provided in any setting
- Documentation of all hospital admissions and follow-up care, inpatient and outpatient care, including hospital discharge summaries, hospital history and physicals and operative report
- Labor and delivery record for any child seen since birth
- A signed document stating with whom protected health information may be shared

Organization

- The medical record is legible to someone other than the writer
- Each patient has an individual record
- Chart pages are bound, clipped or attached to the file
- Chart sections are easily recognized for retrieval of information
- A release document for each Member authorizing ConnectiCare to release medical information for the facilitation of medical care

Retrieval

- The medical record is available to the Provider at each encounter
- The medical record is available to ConnectiCare for purposes of quality improvement
- The medical record is available to the applicable state and/or federal agency and the external quality review organization upon request
- The medical record is available to the Member upon their request
- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with state and federal requirements and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 years
- An established and functional data recovery procedure in the event of data loss

Confidentiality

ConnectiCare Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas
- Maintain records and information in an accurate and timely manner
- Ensure timely access by Members to the records and information that pertain to them
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information
- Protect medical records from unauthorized access
- Restrict access to computerized confidential information
- Take precautions to prevent inadvertent or unnecessary disclosure of protected health information
- Educate and train all staff on handling and maintaining protected health care information
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity and social determinants of health is protected

Additional information on medical records is available from your local ConnectiCare Quality department. For additional information regarding HIPAA, please see the **Compliance** section of this Provider Manual.

Advance directives (Patient Self-Determination Act)

ConnectiCare complies with the advance directive requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance directives are a written choice for health care. There are two (2) types of advance directives:

- **Appointment of health care representative**: allows an agent to be appointed to carry out health care decisions.
- **Living will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

When there is no advance directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult ConnectiCare Members 18 years old and up, of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives.

Members who would like more information are instructed to contact the ConnectiCare Member Contact Center or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives for forms available to download. Additionally,

the ConnectiCare website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

ConnectiCare network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. ConnectiCare will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS regulations give Members the right to file a complaint with ConnectiCare or the State survey and certification agency if the Member is dissatisfied with ConnectiCare's handling of advance directives and/or if a Provider fails to comply with advance directive instructions.

ConnectiCare will notify the Provider of an individual Member's advance directive identified through case management, care coordination or case management. Providers are instructed to document the presence of an advance directive in a prominent location of the medical record. Advance directive forms are state-specific to meet state regulations.

ConnectiCare that there will be documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Access to care

ConnectiCare maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists) and behavioral health Providers. Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment access

All Providers who oversee the Member's health care are responsible for providing the following appointments to ConnectiCare Members in the time frames noted.

Medical appointment

Appointment types	Standard
Non-urgent primary care	Within 10 business days

Appointment types	Standard
Urgent Care	Within 48 hours
After Hours Care	24 hours/day; 7 day/week availability
Non-urgent specialty care	Within 15 business days
Non-urgent ancillary services	Within 15 business days

Behavioral health appointment

Appointment types	Standard
Life Threatening Emergency	Immediately
Non-life Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 business days
Non-urgent appointments for primary care	Within 10 business days
Non-urgent for non-physical mental health	Within 10 business days

Additional information on appointment access standards is available from your local ConnectiCare Quality department.

Office wait time

For scheduled appointments, the wait time in offices should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After hours

All Providers must have backup (on-call) coverage after hours or during the Provider's absence or unavailability. ConnectiCare requires Providers to maintain a 24-hour telephone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after hours is not acceptable.

Women's health access

ConnectiCare allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by ConnectiCare as providing obstetric and gynecological services. Member access to obstetric and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetric and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available from your local ConnectiCare Quality department.

Monitoring access for compliance with standards

Access to care standards are reviewed, revised as necessary and approved by the Quality Improvement and Health Equity Transformation Committee on an annual basis.

Provider network adherence to access standards is monitored via one (1) or more of the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time and identification of barriers. Results of analysis are reported to the Quality Improvement and Health Equity Transformation Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Health Equity Transformation Committee.

Quality of provider office sites

ConnectiCare Providers are to maintain office-site and medical record keeping practices standards. ConnectiCare continually monitors Member appeals and complaints/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. ConnectiCare assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Adequacy of medical/treatment record keeping; paper records
- Adequacy of medical/treatment record keeping; electronic records
- Patient safety including adequacy of equipment

Physical accessibility

ConnectiCare evaluates office sites as applicable to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site and ease of access for patients with physical disabilities.

Physical appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting and patient safety as needed.

Adequacy of waiting and examining room space

During the site visit as required, ConnectiCare assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration and confidentiality of facilities

Facilities contracted with ConnectiCare must demonstrate overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and the parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR-certified employee is available
- Yearly Occupational Safety and Health Administration (OSHA) training (fire, safety, blood-borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, contracts and evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A Clinical Laboratory Improvement Amendment (CLIA) waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.

- Drug refrigerator temperatures are documented daily.

Services to enrollees under 21 years of age

ConnectiCare maintains systematic and robust monitoring mechanisms to ensure all preventive services for Enrollees under 21 years of age are timely according to required preventive health guidelines. All Enrollees under 21 years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the preventive health guidelines located on the ConnectiCare Provider website at connecticare.com and referenced in the **Benefits and Covered Services** section of this Provider Manual.

Well-child/adolescent visits

Visits consist of age-appropriate components, that include but are not limited to:

- Comprehensive health and developmental history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive unclothed physical examination
- Appropriate immunizations according to the Advisory Committee on Immunization Practices
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool
- Vision screening for preventive services. Only medically necessary services are covered. Pediatric routine vision services (one [1] eye exam per year) is accessed by Members through the EyeMed network.
- Hearing screening for preventive services
- Dental assessment and services
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention
- Periodic objective screening for social-emotional development using a recognized, standardized tool
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit

Diagnostic services, treatment or services medically necessary to correct or ameliorate defects, physical or mental illnesses and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's covered benefits services. Members should be referred to an appropriate source of care for any required services that are not covered services.

ConnectiCare shall have no obligation to pay for services that are not covered services.

Monitoring for compliance with standards

ConnectiCare monitors compliance with the established performance standards as outlined above at least annually. Performance below ConnectiCare's standards may result in a corrective action plan (CAP) with a request that the Provider submits a written CAP to ConnectiCare within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality improvement activities and programs

ConnectiCare maintains an active QI program. The QI program provides structure and key processes to carry out our ongoing commitment to the improvement of care and service. ConnectiCare focuses on reducing health care disparities through the QI program. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health management and case management

The ConnectiCare health management and case management programs provide for the identification, assessment, stratification and implementation of appropriate interventions for Members with chronic diseases.

For additional information please refer to the Health Management and Case Management headings in the **Health Care Services** section of this Provider Manual.

Clinical practice guidelines

ConnectiCare adopts and disseminates clinical practice guidelines (CPG) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority.

ConnectiCare CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression

- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

All CPGs are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year. CPGs are distributed to Providers at connecticare.com and the Provider Manual. Notification of the availability of the CPGs is published in the ConnectiCare Provider Newsletter.

Preventive health guidelines

ConnectiCare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC), in accordance with CMS guidelines. Diagnostic preventive procedures include but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on ConnectiCare's website.
- Recommendations for Preventive Pediatric Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on ConnectiCare's website.
- Recommended Adult Immunization Schedule for ages 19 Years or Older (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on ConnectiCare's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger (United States). These recommendations are revised every year by the CDC. Link to current recommendations are included on ConnectiCare's website.

All preventive health guidelines are updated at least annually and more frequently, as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, preventive health guidelines are distributed to Providers at

connecticare.com and the Provider Manual. Notification of the availability of the preventive health guidelines is published in the ConnectiCare Provider Newsletter.

Culturally and linguistically appropriate services

ConnectiCare works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about ConnectiCare's program and services, please see the **Culturally and Linguistically Appropriate Services** section of this Provider Manual.

Measurement of clinical and service quality

ConnectiCare monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- HEDIS®
- Qualified Health Plan (QHP) Enrollee Experience Survey
- Behavioral Health Satisfaction Assessment
- Provider Satisfaction Survey
- Effectiveness of quality improvement initiatives

ConnectiCare evaluates continuous performance according to or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and facilities must allow ConnectiCare to use its performance data collected in accordance with the Provider Agreement with ConnectiCare. The use of performance data may include but is not limited to the following:

1. Development of quality improvement activities
2. Public reporting to consumers
3. Preferred status designation in the network
4. Reduced Member cost sharing

ConnectiCare's most recent results can be obtained from your local ConnectiCare Quality department or by visiting our website at connecticare.com.

HEDIS®

ConnectiCare utilizes NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

Qualified health plan (QHP) enrollee experience survey

The QHP Enrollee Experience Survey is a consumer experience survey that assesses enrollee experience with QHPs offered through Marketplaces. The QHP Enrollee Experience Survey is fielded nationally by HHS-approved survey vendors using a standardized protocol to facilitate QHP comparison both within and across Marketplaces.

The QHP Enrollee Experience Survey was designed to collect accurate and reliable information from consumers about their experience with the health care they received through Health Insurance Marketplace QHPs. The survey includes a set of core questions that address key areas of care and service, with some questions grouped to form composites.

QHP Enrollee Experience Survey topics include:

- Access to care
- Access to information
- Care coordination
- Cost
- Cultural competence
- Doctor’s communication
- Plan administration
- Prevention

Behavioral health satisfaction assessment

ConnectiCare obtains feedback from Members about their experience, needs and perceptions of accessing behavioral health care services. This feedback is collected at least annually to understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, among other areas.

Provider satisfaction survey

Recognizing that HEDIS® and the QHP Enrollee Experience Survey focus on Member experience with health care Providers and health plans, ConnectiCare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to ConnectiCare, as this is one of the primary methods used to identify improvement areas

pertaining to the ConnectiCare Provider network. The survey results have helped establish improvement activities relating to ConnectiCare's specialty network, inter-Provider communications and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of quality improvement initiatives

ConnectiCare monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, ConnectiCare also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements.

Quality rating system for marketplace

Based on Section 1311(c)(3) of the Affordable Care Act, CMS developed the Quality Rating System (QRS) to:

- Provide comparable and useful information to consumers about the quality of health care services provided by QHPs.
- Facilitate oversight of QHP issuer compliance with Marketplace quality standards.
- Provide actionable information for improving quality and performance.

Quality ratings are calculated for each eligible QHP product using clinical quality and enrollee experience survey data. Based on results, CMS will calculate and produce quality performance ratings for each health plan on a 1 to 5-star rating scale.

Measures are organized into a hierarchical structure designed to make the QRS scores and ratings more understandable. They include, but are not limited, to the following domains:

- Clinical effectiveness
- Patient safety
- Prevention
- Access and coordination
- Doctor and care
- Efficiency and affordability
- Plan service

What can providers do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed
- Check that staff are properly coding all services provided
- Be sure patients understand what *they* need to do.

ConnectiCare has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity Essentials portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and QHP Enrollee Experience Survey Star Ratings measures, contact the local ConnectiCare Quality department.

11. Risk adjustment accuracy and completeness

What is risk adjustment?

CMS defines risk adjustment as a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to ConnectiCare Members and prepares for resources that may be needed in the future to treat Members who have chronic conditions.

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for ConnectiCare Members by using one of the automated methods available and supported by the Provider's electronic medical records (EMR), including but not limited to Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource).

The CDA or CCD document should include signed clinical notes or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for ConnectiCare Members to the interoperability vendor designated by ConnectiCare.

The Provider will participate in ConnectiCare's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is HIPAA-compliant mechanism for exchanging healthcare information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have a Direct Address, the Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the CMS requirement of having Provider's Digital Contact Information added in National Plan and Provider Enumeration System (NPPES).
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with ConnectiCare's established interoperability partner to get an account established.

Risk adjustment data validation (RADV) audits

As part of the regulatory process, CMS may conduct RADV audits to ensure that the diagnosis data submitted by ConnectiCare is complete and accurate. All

claims/encounters submitted to ConnectiCare are subject to state and/or federal and internal health plan auditing. If ConnectiCare is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Your role as a Provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. This will ensure ConnectiCare receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by ConnectiCare and reviewed with the Member
- Be compliant with the CMS National Correct Coding Initiative (NCCI)
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity
- Only use diagnosis codes confirmed during a Provider visit with the Member. The visit may be face-to-face or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes
- Contain the Member's name and date of service
- Have the Provider's signature and credentials

Contact information

For questions about ConnectiCare's risk adjustment programs, please contact the local ConnectiCare Provider Relations representatives.

12. Compliance

Fraud, waste and abuse

Introduction

ConnectiCare is dedicated to the detection, prevention, investigation and reporting of potential health care fraud, waste and abuse. As such, ConnectiCare's Compliance department maintains a comprehensive plan, which addresses how ConnectiCare will uphold and follow state and federal statutes and regulations pertaining to fraud, waste and abuse. The plan also addresses fraud, waste and abuse prevention, detection and correction along with and the education of appropriate employees, vendors, Providers and associates doing business with ConnectiCare.

ConnectiCare's Special Investigation Unit (SIU) supports Compliance in its efforts to prevent, detect, and correct fraud, waste and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or Law enforcement agency.

Mission statement

Our mission is to pay claims correctly the first time and that mission begins with the understanding that we need to proactively detect fraud, waste and abuse, correct it and prevent it from re-occurring. Since not all fraud, waste or abuse can be prevented, ConnectiCare employs processes that retrospectively and address fraud, waste or abuse that may have already occurred. ConnectiCare strives to detect, prevent, investigate and report suspected health care fraud, waste and abuse in order to reduce health care costs and to promote quality health care.

Regulatory requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally-funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim
- Acts in deliberate ignorance of the truth or falsity of the information in a claim
- Acts in reckless disregard of the truth or falsity of the information in a claim

The Act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services,

submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Anti-kickback statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration - as well as the recipients of kickbacks-those who solicit or receive remuneration.

ConnectiCare conducts all business in compliance with federal and state AKS statutes and regulations and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by federal and state health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume or a Provider who offers remuneration to patients to influence them to use their services.

Under ConnectiCare's policies, Providers may not offer, solicit an offer, provide or receive items of value of any kind that are intended to induce referrals of federal health care program business. Providers must not, directly or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining or directing our business. This includes giving, favors, preferential hiring or anything of value to any government official.

Marketing guidelines and requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both state and federal.

Under ConnectiCare's policies, marketing means any communication, to a beneficiary who is not enrolled with ConnectiCare, that can reasonably be interpreted as intended to influence the beneficiary to enroll with ConnectiCare's Medicaid, Marketplace or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another health plan's products.

Restricted marketing activities vary from state to state but generally relate to the types and forms of communications that health plans, Providers and others can have with

Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach and other types of communications.

Stark statute

The Physicians Self-Referral Law (Stark law) prohibits physicians from referring patients to receive “designated health services” payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission or causing the submission of claims in violation of the law’s restrictions on referrals. “Designated health services” are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

Sarbanes-Oxley Act of 2002

The Sarbanes-Oxley Act requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR § 455.2).

Waste means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse and ineffective use. Inefficiency waste includes redundancy, delays and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to state and federal health care programs.

Abuse means Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to state and federal health care programs or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to state and federal health care programs (42 CFR § 455.2).

Examples of fraud, waste and abuse by a Provider

The types of questionable Provider schemes investigated by ConnectiCare include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark law).
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a ConnectiCare Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of medical necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a ConnectiCare Member ID card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident-to-billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are medically necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered and instead uses a code for a like service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of fraud waste and abuse by a Member

The types of questionable Member schemes investigated by ConnectiCare include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud state and federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.

- Forgery related to health care.
- Prescription diversion which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else.

Review of Provider claims and claim system

ConnectiCare claims examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste and abuse. If the claims examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

The claim payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices, ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

ConnectiCare performs auditing to ensure the accuracy of data input into the claim system. The claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment of fraud, waste and abuse detection activities

Through the implementation of claim edits, ConnectiCare's claim payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

ConnectiCare has a pre-payment claim auditing process that identifies frequent correct coding billing errors ensuring that claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific state Medicaid guidelines, federal CMS guidelines, American Medical Association (AMA) and published specialty-specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, NCCI files, Local Coverage Determination/National Coverage Determination (LCD/NCD) and state-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, ConnectiCare may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon the Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment recovery activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with ConnectiCare and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to ConnectiCare under the Provider Agreement with ConnectiCare or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement with ConnectiCare, the parties agree that ConnectiCare shall in its sole discretion exercise the terms that are expressed in the Provider Agreement with ConnectiCare, the terms that are expressed here, its rights under law and equity or some combination thereof.

Ther Provider will provide ConnectiCare, governmental agencies and their representatives or agents, access to examine, audit and copy any and all records deemed by ConnectiCare, in ConnectiCare's sole discretion, necessary to determine compliance with the terms of the Provider Agreement with ConnectiCare, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where the Provider provides services to any ConnectiCare Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by ConnectiCare and without charge to ConnectiCare. In the event ConnectiCare identifies fraud, waste or abuse, the Provider agrees to repay funds or ConnectiCare may seek recoupment.

If a ConnectiCare auditor is denied access to the Provider's records, all of the claims for which the Provider received payment from ConnectiCare is immediately due and owing. If the Provider fails to provide all requested documentation for any claim, the entire amount of the paid claim is immediately due and owing. ConnectiCare may offset such amounts against any amounts owed by ConnectiCare to the Provider. The Provider must comply with all requests for documentation and records timely (as reasonably requested by ConnectiCare) and without charge to ConnectiCare. Claims for which the Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

The Provider acknowledges that HIPAA specifically permits a covered entity, such as the Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that in order to receive payment from ConnectiCare, the Provider is required to allow ConnectiCare to conduct audits of its pertinent records to verify the services performed and the payment claimed and that such audits are permitted as a payment activity of the Provider under HIPAA and other applicable privacy laws.

Claim auditing

ConnectiCare shall use established industry claim adjudication and/or clinical practices, state and federal guidelines and/or ConnectiCare's policies and data to determine the appropriateness of the billing, coding and payment.

The Provider acknowledges ConnectiCare's right to conduct pre and post-payment billing audits. The Provider shall cooperate with ConnectiCare's SIU and audits of claims and payments by providing access at reasonable times to requested claim information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment.

In reviewing medical records for a procedure, ConnectiCare reserves the right and where unprohibited by regulation, to select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that ConnectiCare paid in error. The estimated proportion or error rate may be extrapolated across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. ConnectiCare asks that you provide ConnectiCare or ConnectiCare's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If ConnectiCare's SIU suspects that there is fraudulent or abusive activity, ConnectiCare may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, ConnectiCare reserves the right to recover the full amount paid or due to you.

Provider education

When ConnectiCare identifies through an audit or other means a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, ConnectiCare may determine that a Provider education visit is appropriate.

ConnectiCare will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a CAP to ConnectiCare addressing the issues identified and how it will cure these issues moving forward.

Reporting fraud, waste and abuse

Suspected cases of fraud, waste or abuse must be reported to ConnectiCare by contacting the ConnectiCare Alertline. The ConnectiCare Alertline is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. The ConnectiCare Alertline telephone and web-based reporting is available 24 hours a day, 7 days a week, 365

days a year. When a report is made, callers can choose to remain confidential or anonymous. When calling the ConnectiCare Alertline, a trained professional at NAVEX Global will note the caller's concerns and provide them to the ConnectiCare compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked concluding with the submission of the report. Reports to the ConnectiCare Alertline can be made from anywhere within the United States with telephone or internet access.

The ConnectiCare Alertline can be reached at (866) 606-3889 or use the service's website to make a report at any time at molinahealthcare.alertline.com.

Fraud, waste or abuse cases may also be reported to ConnectiCare's Compliance department anonymously without fear of retaliation.

ConnectiCare
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

The following information must be included when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, ConnectiCare Member ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the state at:

Email: Complaint Form to ag.fraud@ct.gov
Telephone Fraud Hotline: call (860) 808-5354
Fax: Complaint Form to (860) 808-5391
Mail: Complaint Form (along with supporting information) to the following address:
Office of the Attorney General
State of Connecticut
Antitrust and Government Program Fraud Department
FRAUD COMPLAINT
PO Box 120
Hartford, CT 06141-0120

HIPAA requirements and information

ConnectiCare's commitment to patient privacy

Protecting the privacy of Members' personal health information is a core responsibility that ConnectiCare takes very seriously. ConnectiCare is committed to complying with all federal and state laws regarding the privacy and security of Members' protected health information (PHI).

Provider responsibilities

ConnectiCare expects that its contracted Providers will respect the privacy of ConnectiCare Members (including ConnectiCare Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. ConnectiCare provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how ConnectiCare uses and discloses their PHI and includes a summary of how ConnectiCare safeguards their PHI.

Telehealth/telemedicine Providers: telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable laws

Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead, there is a patchwork of laws that Providers must comply with. In general, most health care Providers are subject to various laws and regulations pertaining to the privacy of health information, including, without limitation, the following:

1. **Federal laws and regulations**
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - 42 C.F.R. Part 2
   - Medicare and Medicaid laws
   - The Affordable Care Act
2. **State medical privacy laws and regulations.**
   Providers should be aware that HIPAA provides a floor for patient privacy, but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Artificial intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to ConnectiCare Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and

quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician. In addition, the Provider shall not use AI-generated voice technology, including but not limited to AI voice bots, voice cloning, or synthetic speech systems to initiate or conduct outbound communications to ConnectiCare. The prohibition includes, but is not limited to, communications for billing, eligibility verification, prior authorization, or any other administrative function.

Notwithstanding the foregoing, the Provider shall give advance written notice to your ConnectiCare Contract Manager (for any AI used by the Provider that may impact the provision of covered services to ConnectiCare Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by ConnectiCare, the Provider further agrees to (i) allow ConnectiCare to audit Providers' AI use, as requested by ConnectiCare from time to time, and (ii) to cooperate with ConnectiCare with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to ConnectiCare Members.

If you have additional questions, please contact your ConnectiCare Contract Manager.

Uses and disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review and retrospective review of "services[2].
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship and the disclosure is for the following health care operations activities:
    - Quality improvement
    - Disease management
    - Care management and care coordination
    - Training programs

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

- Accreditation, licensing and credentialing

Importantly, this allows Providers to share PHI with ConnectiCare for our health care operations activities, such as HEDIS® and quality improvement.

Confidentiality of substance use disorder patient records

Federal Confidentiality of Substance Use Disorder Patient Records under 42 USC § 290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2") apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. "SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 CFR Part 2. Providers that are Part 2 Programs must comply with the requirements of 42 CFR Part 2, as amended from time to time.

SUD Records are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, 42 CFR Part 2 is more restrictive than HIPAA and does not allow disclosure without the patient's written consent except as set forth in 42 CFR Part 2. Any disclosure of SUD Records to ConnectiCare with the written consent of the patient, by a Provider that is a Part 2 Program, must meet the notice requirements of 42 CFR Part 2, specifically Sections 2.31 and 2.32, and shall include a copy of the patient's consent or a clear explanation of the scope of the consent provided.

Providers that are Part 2 Programs pursuant to 42 CFR Part 2 must promptly inform ConnectiCare that they are a Part 2 Program.

Inadvertent disclosures of PHI

ConnectiCare may, on occasion, inadvertently misdirect or disclose PHI pertaining to ConnectiCare Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected ConnectiCare Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of ConnectiCare.

Written authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

Patient rights

Patients are afforded various rights under HIPAA. ConnectiCare Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of privacy practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy

practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for restrictions on uses and disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for confidential communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for patient access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request accounting of PHI disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment or health care operations.

HIPAA security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of ConnectiCare Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical – is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity – such as health insurance information – without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to ConnectiCare.

HIPAA transactions and code sets

ConnectiCare strongly supports the use of electronic transactions to streamline health care administrative activities. ConnectiCare Providers are encouraged to submit claims and other transactions to ConnectiCare using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advice

ConnectiCare is committed to complying with all HIPAA transaction and code sets standard requirements. Providers should refer to ConnectiCare's website at connecticare.com for additional information regarding HIPAA standard transactions.

Code sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the NPI rule promulgated under HIPAA. The Provider must obtain an NPI from NPPES for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to ConnectiCare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to ConnectiCare within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters submitted to ConnectiCare.

Additional requirements for delegated Providers

Providers that are delegated for claims and utilization management activities are the "business associates" of ConnectiCare. Under HIPAA, ConnectiCare must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's privacy and security rules.

Reimbursement for copies of PHI

ConnectiCare does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization management
- Care coordination and/or complex medical case management services
- Claims review

- Resolution of an appeal and/or grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment and/or operation purposes
- Collection of HEDIS® medical records.

Information security and cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by ConnectiCare to perform a health plan function(s) and in connection with such delegated functions.

1. Definitions:

   (a) "ConnectiCare Information" means any information: (i) provided by ConnectiCare to Provider; (ii) accessed by Provider or available to Provider on ConnectiCare's Information Systems; or (iii) any information with respect to ConnectiCare or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any ConnectiCare Nonpublic Information.

   (b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized or unlawful destruction, loss, alteration, use, disclosure of or access to ConnectiCare Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition or disclosure of ConnectiCare Information or sustained interruption of service obligations to ConnectiCare.

   (c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

   (d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

   (e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time and including but not limited to the

current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH
ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1 or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:
i. ConnectiCare's proprietary and/or confidential information;
ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and
iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement and at all times maintain, appropriate administrative, technical and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon and ConnectiCare Information that are accessible to or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical and physical safeguards pursuant to HIPAA, HITECH and other applicable U.S. federal, state and local laws.

(a) Policies, Procedures and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards and standards, including as applicable, a written information security program, which ConnectiCare shall be permitted to audit via written request and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and ConnectiCare Information accessible to or held by Provider.

ii. Encryption. Use of encryption to protect ConnectiCare Information, in transit and at rest, accessible to or held by Provider.

iii. Security. Safeguarding the security of the Information Systems and ConnectiCare Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three [3] or more annually) third party vulnerability assessments, physical security controls and personnel training programs that include phishing recognition and proper data management hygiene.

iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a “zero-trust architecture” satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. Provider agrees that any and all ConnectiCare Information will be stored, processed and maintained solely on designated target servers or cloud resources. No ConnectiCare Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider’s designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. Provider agrees to store all ConnectiCare Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported

encryption solution. Provider further agrees that any and all ConnectiCare Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with ConnectiCare and/or any other parties expressly designated by ConnectiCare shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-use. Provider agrees that any and all ConnectiCare Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement with ConnectiCare and this section. Data shall not be distributed, repurposed or shared across other applications, environments or business units of Provider. Provider further agrees that no ConnectiCare Information or data of any kind shall be transmitted, exchanged or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by ConnectiCare .

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade or disrupt Provider's delivery of services to ConnectiCare.

(a) Resilience Questionnaire. Provider shall complete a questionnaire provided by ConnectiCare to establish Provider's resilience capabilities.

(b) BC/DR Plan.

i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and ConnectiCare. The BC/DR Plan shall include the following:

a) Notification, escalation and declaration procedures.
b) Roles, responsibilities and contact lists.
c) All Information Systems that support services provided to ConnectiCare.
d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to ConnectiCare.

e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
f) Detailed list of resources to recover services to ConnectiCare including but not limited to: applications, systems, vital records, locations, personnel, vendors and other dependencies.
g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.
h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to ConnectiCare. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

ii. To the extent that ConnectiCare Information is held by Provider, Provider shall maintain backups of such ConnectiCare Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Notification. Provider shall notify ConnectiCare's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to ConnectiCare or that detrimentally affects Provider's Information Systems or ConnectiCare's Information.

ii. Provider's activation of business continuity plans. Provider shall provide ConnectiCare with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) BC and DR Testing. For services provided to ConnectiCare, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide ConnectiCare a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

(a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects ConnectiCare's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or ConnectiCare Information accessible to or held by Provider, Provider shall notify ConnectiCare's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve ConnectiCare Information, Provider shall notify ConnectiCare's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve ConnectiCare Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to ConnectiCare's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: cyberincidentreporting@molinahealthcare.com

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, Provider will, at ConnectiCare's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by ConnectiCare, (ii) fully cooperate with ConnectiCare to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law) and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving ConnectiCare Information without the prior written consent of ConnectiCare

(e) Following notification of a Cybersecurity Event, Provider must promptly provide ConnectiCare any documentation requested by ConnectiCare to

complete an investigation or, upon request by ConnectiCare, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;
ii. assess the nature and scope of the Cybersecurity Event;
iii. identify ConnectiCare ’s Information that may have been involved in the Cybersecurity Event; and
iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release or use of ConnectiCare Information.

(f) Provider must provide ConnectiCare the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to ConnectiCare concerning the Cybersecurity Event. The information provided to ConnectiCare must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;
ii. a description of how the information was exposed, lost, stolen or breached;
iii. how the Cybersecurity Event was discovered;
iv. whether any lost, stolen or breached information has been recovered and if so, how this was done;
v. the identity of the source of the Cybersecurity Event;
vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information or types of information allowing identification of the consumer;
viii. the period during which the Information System was compromised by the Cybersecurity Event;
ix. the number of total consumers in each State affected by the Cybersecurity Event;
x. the results of any internal review identifying a lapse in either automated controls or internal procedures or confirming that all automated controls or internal procedures were followed;
xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
xii. a copy of Provider’s privacy policy and a statement outlining the steps Provider will take to investigate and if requested by ConnectiCare, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and
xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

(g) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon ConnectiCare's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by ConnectiCare and/or any designated representative or vendor of ConnectiCare. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If ConnectiCare performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement with ConnectiCare will be in compliance with generally recognized industry standards and as provided in Provider's response to ConnectiCare's due diligence/security risk assessment questionnaire; (ii) agrees to inform ConnectiCare promptly of any material variation in operations from what was provided in Provider's response to ConnectiCare's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to ConnectiCare's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement with ConnectiCare.

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between ConnectiCare and Provider, but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between ConnectiCare and Provider, the stricter of the conflicting provisions will control.

13. Claims

Payer ID	**MLNCT**
Availity Essentials portal	**availity.com/providers**
Clean Claim Timely Filing	**Unless otherwise specified by the applicable participation agreement or the member's self-funded plan's provisions, 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services**

Electronic claim submission

For dates of services beginning 01/01/2026: ConnectiCare strongly encourages participating Providers to submit claims electronically, including secondary claims. Electronic claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and claims reach ConnectiCare faster

ConnectiCare offers the following electronic claim submission options:

- Submit claims directly to ConnectiCare via the Availity Essentials portal
- Submit claims to ConnectiCare via your regular EDI clearinghouse using Payer ID MLNCT

Availity Essentials portal

The Availity Essentials portal is a no-cost online platform that offers a number of claim processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) claims with attached files
- Correct/void claims
- Add attachments to previously submitted claims
- Check claim status
- View ERA and EOP
- Create and manage claim templates
- Create and submit a claim appeal with attached files
- View, dispute, resolve claim overpayments

Clearinghouse

ConnectiCare uses The SSI Group as its gateway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit claims to their usual clearinghouse.

If you do not have a clearinghouse, ConnectiCare offers additional electronic claim submission options as shown by logging on to the Availity Essentials portal.

ConnectiCare accepts EDI transactions through our gateway clearinghouse for claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When claims are filed via a clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claim from your clearinghouse
- You should refer to the ConnectiCare Companion Guide for information on the response format and messages
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI claim submission issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact ConnectiCare Provider Relations representatives for additional support.

Timely claim filing

Providers shall promptly submit to ConnectiCare claims for covered services rendered to Members. All claims shall be submitted in a form acceptable to and approved by ConnectiCare and shall include all medical records pertaining to the claim if requested by ConnectiCare or otherwise required by ConnectiCare's policies and procedures. Claims must be submitted by Providers to ConnectiCare within 180 calendar days after the discharge for inpatient services or the date of service for outpatient services. If ConnectiCare is not the primary payer under coordination of benefits or third-party liability, Providers must submit claims to ConnectiCare within 180 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to ConnectiCare within these timelines shall not be eligible for payment and the Provider hereby waives any right to payment.

Claim submission

Participating Providers are required to submit claims to ConnectiCare with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines as well as any criteria explicitly required in the ConnectiCare Billing and Claims page as well as any criteria explicitly required in the Claims Submission section. Providers must utilize electronic billing through a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA-compliant ANSI X 12N

format (e.g., 837I for institutional claims, 837P for professional claims and 837D for dental claims) and use electronic Payer ID number MLNCT. For Members assigned to a delegated medical group/IPA that processes its own claims, please verify the claim submission instructions on the ConnectiCare Member ID card.

Providers must bill ConnectiCare for services with the most current CMS-approved diagnostic and procedural coding available as of the date the service was provided or for inpatient facility claims, the date of discharge.

National Provider Identifier (NPI)

A valid NPI is required on all claim submissions. Providers must report any changes in their NPI or subparts to ConnectiCare as soon as possible, not to exceed 30 calendar days from the change. ConnectiCare supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. ConnectiCare may validate the NPI submitted in a claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required elements

Electronic submitters should use the Implementation Guide and ConnectiCare Companion Guide for format and code set information when submitting or receiving files directly with ConnectiCare. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the ConnectiCare website at connecticare.com for regularly updated information regarding ConnectiCare's companion guide requirements.

Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for compliance with the Strategic National Implementation Process (SNIP) levels 1 to 5.

The following information must be included on every claim, whether electronic or paper:

- Member name, date of birth and ConnectiCare Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable (anesthesia claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)

- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), NDC Units, Units of Measure and Days or Units for medical injectables
- E-signature
- Service facility location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of claim submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Inaccurate, incomplete or untimely submissions and re-submissions may result in denial of the claim.

EDI (clearinghouse) submission

Corrected claim information submitted via EDI submission are required to follow electronic claim standardized ASC X12N 837 formats. Electronic claims are validated for compliance with SNIP levels 1 to 5. The 837 claim format allows you to submit changes to claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “claim frequency codes.” Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim. Use the below frequency codes for claims that were previously adjudicated.

Claim frequency code	Description	Action
7	Use to replace an entire claim.	ConnectiCare will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8	Use to eliminate a previously submitted claim.	ConnectiCare will void the original claim from records based on request.

When submitting claims noted with claim frequency code 7 or 8, the original claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original claim number, adjustment requests will generate a compliance error and the claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original claim number will not be adjusted.

Paper claim submission

Participating Providers should submit claims electronically. If electronic claim submission is not possible please submit paper claims to the following address:

ConnectiCare Claims
PO Box 36010
Louisville, KY 40233

When submitting paper claims:

- Paper claim submissions are not considered to be “accepted” until received at the appropriate claims PO Box; claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper claims are required to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) claim forms.
- Paper claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms and any altering to include claims with handwriting.
- Claims must be typed with either 10 or 12-point Times New Roman font, using black ink.
- Link to paper claims submission guidance from CMS: cms.gov/medicare/billing/electronicbillingeditrans/1500

Corrected claim process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

ConnectiCare strongly encourages participating Providers to submit corrected claims electronically via EDI or the Availity Essentials portal.

All corrected claims:

- Must be free of handwritten or stamped verbiage (paper claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 claim form (paper claims).
- Original claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper claim or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the National Uniform Claim Committee (NUCC) manual for CMS-1500 claim forms or the Uniform Billing (UB) Editor for CMS-1450 (UB-04) claim forms.

Corrected claims must be sent within 100 additional days from original submission timely filing limits of the claim.

Corrected claim submission options:

- Submit corrected claims directly to ConnectiCare via the Availity Essentials portal.
- Submit corrected claims to ConnectiCare via your regular EDI clearinghouse

Coordination of benefits (COB) and third-party liability (TPL)

Our benefit plans are subject to subrogation and COB rules.

Subrogation — ConnectiCare retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under state and federal law and the Member's benefit plan. If third-party liability is suspected or known, please refer pertinent case information to ConnectiCare's vendor, Rawlings at (888) 258-8060.

COB — Coordination of Benefits (COB) exists when an individual has more than one (1) policy at the same time and order of benefits are established pursuant to national and/or state guidelines. Primary payers should be billed prior to claim submission to secondary/tertiary payers to cover any remaining liability.

Workers' Compensation — Workers' compensation is primary payer when a Member's damages are related to an incident that occurred while working. Claims related to a workers' compensation incident should be submitted to the carrier prior to submitting to ConnectiCare for payment.

Medicare — Medicare is the primary payer for covered services and providers accepting Medicare assignment except in the following instances:

- Members Entitled to Medicare due to Age: Commercial health plans are primary to Medicare if the employer has 20 or more employees and the Member is actively working.
- Disabled employees (large group health plan): Commercial health plans are primary to Medicare if the employer has 100 or more employees and the Member is actively working.
- End-Stage Renal Disease (ESRD): If a Member is entitled to Medicare due to ESRD while covered under an employer's group health plan, commercial group health plan is primary for the first 30 months after becoming eligible for Medicare. After the 30 months, Medicare is the primary payer. However, if the commercial group health plan was secondary to Medicare when the Member became entitled due to ESRD, Medicare will remain the primary payer and no 30-month coordination period is required.

Hospital-acquired conditions (HAC) and present on admission (POA) program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee-for-service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidence-based guidelines. CMS titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting.”

The following is a list of CMS hospital-acquired conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission:

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Diabetic Ketoacidosis
    b) Nonketotic Hyperosmolar Coma
    c) Hypoglycemic Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
10) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Bypass
    b) Gastroenterostomy
    c) Laparoscopic Gastric Restrictive Surgery
11) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
12) Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

14) Iatrogenic Pneumothorax with Venous Catheterization

What this means to Providers

- Acute Inpatient Prospective Payment System (IPPS) hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization

For additional information regarding the Medicare HAC/POA program, including billing requirements, please refer to the CMS website at cms.hhs.gov/hospitalacqcond.

ConnectiCare coding policies and payment policies

Frequently requested information on ConnectiCare's coding policies and payment policies is available on the connecticare.com website. Questions can be directed to ConnectiCare Provider Relations representatives.

Reimbursement guidance and payment guidelines

Providers are responsible for submission of accurate claims. ConnectiCare requires coding of both diagnoses and procedures for all claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- For procedures:
  - Professional and outpatient claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 (HCPCS codes)
  - Inpatient hospital claims require International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes

Furthermore, ConnectiCare requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

ConnectiCare utilizes a claim adjudication system that encompasses edits and audits that follow federal and requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by CMS, including:
  - NCCI edits, including procedure to procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). If a professional organization has a more stringent/restrictive standard than a federal MUE the professional organization standard may be used.
  - Medicare National Coverage Determinations (NCD)
  - Medicare Local Coverage Determinations (LCD)
  - CMS Physician Fee Schedule RVU indicators
- CPT guidance published by AMA

- ICD-10 guidance published by the National Center for Health Statistics
- Other coding guidelines published by industry-recognized resources
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than federal guidelines.
- ConnectiCare policies based on the appropriateness of health care and medical necessity.
- Payment policies published by ConnectiCare.

Telehealth claims and billing

Providers must follow CMS guidelines as well as state-level requirements.

All telehealth claims for ConnectiCare Members must be submitted to ConnectiCare with the correct codes for the plan type in accordance with applicable billing guidelines. For additional information please refer to ConnectiCare's Telehealth and Virtual Care Services policy.

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. ConnectiCare uses NCCI standard payment methodologies.

NCCI procedure to procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on the NCCI coding manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes MUE which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General coding requirements

Correct coding is required to properly process claims. ConnectiCare requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date

of service for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one (1) physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS codes

ConnectiCare utilizes ICD-10-CM and ICD-10-PCS billing rules and will deny claims that do not meet ConnectiCare's ICD-10 claim submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the date of service for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of service (POS) codes

POS codes are two (2)-digit codes placed on health care professional claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS code should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS code for the procedure/service on that line.

Type of bill

Type of bill is a four (4)-digit alphanumeric code that gives three (3) specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue codes

Revenue codes are four (4)-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis related group (DRG)

Facilities contracted to use DRG payment methodology submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment.

ConnectiCare processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the ConnectiCare-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National drug code (NDC)

The NDC number must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, CMS-1450 (UB-04) or its electronic equivalent.

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC number that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding sources

Definitions

CPT – AMA-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three (3) types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – CMS-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – maintained by the CDC within the Department of Health and Human Services (HHS).

ICD-10-PCS –used to report procedures for inpatient hospital services.

Claim auditing

ConnectiCare shall use established industry claims adjudication and/or clinical practices, state and federal guidelines and/or ConnectiCare's policies and data to determine the appropriateness of the billing, coding and payment.

The Provider acknowledges ConnectiCare's right to conduct pre and post-payment billing audits. The Provider shall cooperate with ConnectiCare's SIU and audits of claims and payments by providing access at reasonable times to requested claims information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, ConnectiCare reserves the right, and where unprohibited by regulation, to select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that ConnectiCare paid in error. The estimated proportion or error rate may be extrapolated across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claim review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. ConnectiCare asks that you provide us or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If ConnectiCare's SIU suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, ConnectiCare reserves the right to recover the full amount paid or due to you.

Timely claim processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with ConnectiCare. Unless the Provider and ConnectiCare or contracted medical group/IPA have agreed in writing to an alternate schedule, ConnectiCare will process the claim for service within 60 calendar days for paper and 20 calendar days for electronic after receipt of clean claims.

The receipt date of a claim is the date ConnectiCare receives notice of the claim.

Electronic claim payment

Participating Providers are required to enroll for EFT and ERA. Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow

Providers to reduce paperwork, provides searchable ERAs and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment and Providers are not required to be in-network to enroll. ConnectiCare uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at connecticare.com or by contacting the Provider Contact Center.

Overpayments and incorrect payments refund requests

ConnectiCare requires network Providers to report to ConnectiCare when they have received an overpayment and to return the overpayment to ConnectiCare within 60 calendar days after the date on which the overpayment was identified and notify ConnectiCare in writing of the reason for the overpayment.

If, as a result of retroactive review of claim payment, ConnectiCare determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment
2. Submit request to offset from future claim payments
3. Dispute overpayment findings

A copy of the overpayment request letter and details are available in the Availity Essentials portal.

In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment or check status. This is ConnectiCare's preferred method of communication.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are ConnectiCare standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date and subscriber information. For members with Commercial COB, ConnectiCare will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. A Provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. ConnectiCare will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a claim for an overpayment made by ConnectiCare which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed ConnectiCare may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to ConnectiCare or the date that the Provider receives a payment from ConnectiCare that reduces or deducts the overpayment.

Claim disputes/reconsiderations/appeals

Information on claim disputes/reconsiderations/appeals is located in the **Complaints, Grievance and Appeals Process** section of this Provider Manual.

Balance billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of ConnectiCare to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Fraud, waste and abuse

Failure to report instances of suspected fraud, waste and abuse is a violation of the law and subject to the penalties provided by law. For additional information please refer to the **Compliance** section of this Provider Manual.

Encounter data

Each Provider, capitated Provider or organization delegated for claims processing is required to submit Encounter data to ConnectiCare for all adjudicated claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the QI program and HEDIS® reporting.

Encounter data must be submitted at least monthly and within 30 days from the date of service in order to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA-compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional and 837D – Dental. Data must be submitted with claim level detail for all non-institutional services provided.

ConnectiCare has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA-compliant) or denied by ConnectiCare. Encounters must be corrected and resubmitted within 15 days from the rejection/denial.

ConnectiCare has created 837P, 837I and 837D Companion Guides with the specific submission requirements available to Providers.

When encounters are filed electronically Providers should receive two (2) types of responses:

- First, ConnectiCare will provide a 999 acknowledgement of your transmission.
- Second, ConnectiCare will provide a 277CA response file for each transaction.

14. Complaints, grievance and appeals process

ConnectiCare Members or Member's authorized representatives have the right to file a grievance and submit an appeal through a formal process. All grievances and appeals must be submitted to ConnectiCare for resolution.

This section addresses the identification, review and resolution of Member grievances and appeals. Below is ConnectiCare's Complaints, Grievance and Appeals Process.

Complaints

A complaint is any dissatisfaction with ConnectiCare or any Participating Provider that is not related to the denial of health care services. For example, a Member may be dissatisfied with the hours of availability of their doctor. Issues relating to the denial of health care services are Appeals and should be filed with ConnectiCare in the manner described in the Internal Appeals section below.

For Member complaints, call the following numbers for assistance:

- ConnectiCare at (800) 251-7722, Monday through Friday, 8 a.m.–6 p.m. ET.
- Deaf or hard of hearing, contact ConnectiCare by dialing 711 for the TTY/TDD Relay Service.

Members can also write to ConnectiCare at:

ConnectiCare Appeals and Grievances
c/o Firstsource
PO Box 36030
Louisville, KY 40233-6030

Additional information can be found on ConnectiCare's website at connecticare.com.

Members may also contact the Connecticut Insurance Department at:

- Phone: (860) 297-3910
- Email: externalreview@ct.gov
- Fax: (860) 297-3872
- Web: ct.gov/cid

ConnectiCare recognizes the fact that Members may not always be satisfied with the care and services provided by our contracted doctors, hospitals and other Providers. ConnectiCare will respond to the complaint no later than 90 days from when the complaint is received. This period may be extended if there is a delay in obtaining the documents or records that are necessary to resolve the complaint or if the Member and ConnectiCare agree in writing to extend the period.

Pending the resolution of the complaint, ConnectiCare will not terminate the Member's coverage for any reason which is the subject of the complaint, except that ConnectiCare does have the right to terminate the Member's coverage where ConnectiCare has made

a good faith, reasonable effort to resolve the complaint and termination is otherwise permitted.

Internal appeals and external review

Definitions

Adverse Benefit Determination – means a decision by ConnectiCare:

1. To deny, reduce, fail to provide, or terminate a requested health care service or payment in whole or in part, due to any of the following:
    a. A determination that the health care service does not meet ConnectiCare's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
    b. A determination that a health care service is not a Covered Service;
    c. The imposition of an exclusion source of injury, network, or any other limitation on benefits that would otherwise be covered.

2. Not to issue individual health insurance coverage to an applicant, including initial eligibility determinations;

3. To rescind coverage on a health benefit plan.

Final Adverse Benefit Determination – means an Adverse Benefit Determination that is upheld after the internal appeal process.

Urgent Care Service – means a medical service where the application of non-Urgent Care Service time frames:

- Could seriously jeopardize the Member's life, health, ability to regain maximum function, or the Member's unborn child; or,
- In the opinion of the treating physician, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Appointing a representative

If the Member would like someone to act on the Member's behalf regarding a claim or an appeal of an Adverse Benefit Determination the Member may appoint an authorized representative or ConnectiCare participating Provider. Please send the Member's representative's name, address, and telephone contact information to:

ConnectiCare Appeals and Grievances
c/o Firstsource
PO Box 36030
Louisville, KY, 40233-6030

Tel: (800) 251-7722 or 711 (TTY/TDD)

Fax: (855) 276-7538

The Member must pay the cost of anyone the Member hires to represent or help the Member.

A Provider can appeal on a ConnectiCare Member's behalf if the Member has agreed to treatment; ConnectiCare has received medical records from the Provider; and/or there is a history of paid claims for services from the Provider.

Throughout this "Internal Appeals and External Review" section, any reference to the term "Member" and "Member's" may include the person or entity who initiated the request (including the Member's authorized representative).

Initial denial notices

Notice of an Adverse Benefit Determination will be provided to the Member orally, by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted below.

An Adverse Benefit Determination notice will identify the claim or authorization request involved, convey the specific reason for the Adverse Benefit Determination (including the denial code and its meaning), the specific product provisions upon which ConnectiCare bases the determination, and the contact information for the Connecticut Department of Insurance, which is available to assist the Member with the internal and external appeal processes. The notice will also include a description of any additional information necessary to perfect the claim or request, and an explanation of why such information is necessary. The notice will disclose if any internal product rule, protocol, or similar criterion was relied upon to deny the claim or request. Upon request, a copy of the rule, protocol, or similar criterion will be provided to the Member, free of charge. In addition to the information provided in the notice, the Member has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe ConnectiCare's internal and external (standard and expedited) appeal procedures, the time limits applicable to such procedures following an Adverse Benefit Determination on review and include the release form authorizing ConnectiCare to disclose protected health information pertinent to an external review. It will also include a description of the circumstances under which the Member does not have to exhaust (complete) the internal process or the internal process may be deemed exhausted.

If an Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, then upon request, ConnectiCare will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the product to the Member's medical circumstances.

In the case of an Adverse Benefit Determination involving an Urgent Care Service, the notice will provide a description of ConnectiCare's expedited review procedures, which ConnectiCare describes below.

Internal appeals

The Member must appeal an Adverse Benefit Determination within 180 days after receiving written notice of the denial (or partial denial). The Member may appeal an Adverse Benefit Determination by means of written notice to ConnectiCare, in person, orally, or by mail, postage prepaid.

The request should include:

- The date of the request.
- The Member's name (please print or type).
- The date of the service ConnectiCare denied.
- The Member's identification number claim or request number, and Provider name as shown on the explanation of health care benefits, which the Member will automatically receive when ConnectiCare processes the Member's claim or request.

The Member should keep a copy of the request for their records because no part of it can be returned to the Member.

The Member may request an expedited internal appeal of an Adverse Benefit Determination involving an Urgent Care Service orally or in writing. In such case, all necessary information will be transmitted between ConnectiCare and the Member by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of Adverse Benefit Determinations will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial Adverse Benefit Determination or a subordinate of that person. The Member also has the right to request that the person performing the review must be in the same or similar specialty as the attending health care Provider. The determination will take into account all comments, documents, records, and other information submitted by the Member relating to the claim or request.

On appeal, the Member may review relevant documents, request copies of any relevant information (which will be provided free of charge) and may submit issues and comments in writing. Upon request, the Member may also discover the identity of medical or vocational experts whose advice was obtained on behalf of ConnectiCare in connection with the Adverse Benefit Determination being appealed, as permitted under applicable law.

If ConnectiCare bases the Adverse Benefit Determination in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is Experimental or Investigational, or not Medically Necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the

medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, ConnectiCare will provide to the Member, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide the Member a reasonable opportunity to respond. However, if ConnectiCare receives the new or additional evidence so late that it would be impossible to provide it to the Member in time for the Member to have a reasonable opportunity to respond, the period for providing notice of ConnectiCare's appeal decision will be tolled until the Member has a reasonable opportunity to respond. After the Member responds or has a reasonable opportunity to respond but fails to do so, ConnectiCare will notify the Member of ConnectiCare's decision as soon as reasonably possible, considering the medical circumstances.

The Member's coverage will remain in effect pending the outcome of the Member's internal appeal.

Time periods for decisions on appeal

For appeals of Adverse Benefit Determinations, ConnectiCare will make decisions and provide notice of the decisions as follows:

Time frame for responding to appeal

Request type	Time frame for decision
Pre-service Appeals	ConnectiCare will notify the Member in writing of ConnectiCare's appeal decision as soon as practical, taking into account the medical circumstances, but not later than 30 calendar days after ConnectiCare's receipt of the Member's appeal.
Post-service Appeals	ConnectiCare will notify the Member in writing of ConnectiCare's appeal decision as soon as practical, which generally will not be later than 30 calendar days after ConnectiCare's receipt of all information necessary to complete the appeal. However, in extraordinary circumstances, ConnectiCare will have up to 60 calendar days from the date that the Member submits an appeal to provide the Member with notification of ConnectiCare's appeal decision.
Expedited Appeals (Urgent Care Service Decisions)	ConnectiCare will give the Member oral notice of ConnectiCare's appeal decision as soon as possible, considering the medical circumstances, but not later than either of the following timeframes: • Two (2) business days of ConnectiCare's receipt of all information necessary to complete the appeal. • 72 hours from ConnectiCare's receipt of the Member's appeal

Appeals denial notices

Notice of a Final Adverse Benefit Determination (including a partial denial) will be provided to the Member by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A Final Adverse Benefit Determination will include:

- Sufficient information to identify the claim or request involved.
- The specific reason or reasons for the Final Adverse Benefit Determination, including the denial code and its meaning.
- Reference to the specific product provision upon which the determination is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim or request for benefits.
- If ConnectiCare relied upon any internal ConnectiCare rule, protocol or similar criterion to deny the claim or request, then a copy of the rule, protocol or similar criterion will be provided to the Member, free of charge, along with a discussion of ConnectiCare's decision.
- A statement of the Member's right to external review, a description of the standard and expedited external review process, and the forms for submitting an external review request, including release forms authorizing ConnectiCare to disclose protected health information pertinent to the external review.
- If ConnectiCare bases a Final Adverse Benefit Determination on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of this Agreement to the Member's medical circumstances.
- Notice of voluntary alternative dispute resolution options, as applicable.
- The contact information for the director of the Connecticut Department of Insurance, which is available to assist with the internal and external appeal processes.

In addition to the information provided in the notice, the Member has the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

Exhaustion of the internal claims and appeals processes

A request for standard or expedited external review cannot be made until the Member has exhausted (completed) ConnectiCare's internal claims and appeals processes and received a Final Adverse Benefit Determination. However, in the following circumstances, the Member can request external review prior to exhausting ConnectiCare's internal processes:

- Waiver: Except in regard to post-service appeals, ConnectiCare can waive the exhaustion requirement, in which case the Member can request external review without exhausting ConnectiCare's internal processes.

- Simultaneous Requests for Expedited Internal and External Reviews: The Member may also request an expedited external review of an Adverse Benefit Determination involving an Urgent Care Service at the same time a request is made for an expedited internal appeal of an Adverse Benefit Determination if the Member's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the Member's life or health, or would jeopardize the Member's ability to regain maximum function, if treated after the time frame of an expedited internal appeal (i.e., 72 hours). The Member may not file a request for expedited external review unless the Member also files an expedited internal appeal.
- Deemed Exhaustion:

  If ConnectiCare does not adhere to the requirements outlined above, the internal claims and appeals processes may be deemed exhausted and the Member may have the right to request external review or other remedies under State Law. If the internal processes are deemed exhausted, this is considered a Final Adverse Benefit Determination.

  In order for the internal processes to be deemed exhausted, the Member needs to request a written explanation from ConnectiCare and ConnectiCare will respond in writing within 10 calendar days. The external reviewer or court will review ConnectiCare's explanation along with the Member's request and make a determination of whether the internal processes are exhausted. If the Member's request is rejected, ConnectiCare will notify the Member within 10 calendar days. The Member will have the right to resubmit and pursue an internal appeal of the Adverse Benefit Determination. Time periods for refiling will begin to run upon the Member's receipt of that notice.

External review

Understanding the external review process

After the Member receives a Final Adverse Benefit Determination or if the Member is otherwise permitted, as described above, the Member may request an external review if the Member believes that a health care service has been improperly denied, modified, or delayed on the grounds that the health care service does not meet ConnectiCare's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or is Experimental or Investigational.

An external review will be conducted by an Independent Review Organization (IRO). ConnectiCare will not choose or influence the IRO's reviewers.

There are three (3) types of IRO reviews:

1. Standard external review,
2. Expedited external review, and
3. External review of Experimental or Investigational treatment.

Standard external review

The IRO will provide the Member and ConnectiCare with written notice of its decision within 45 calendar days of its receipt of the Member's request for standard external review.

Expedited external review

An expedited review for urgent medical situations, including reviews of Experimental or Investigational treatment involving an urgent medical situation are normally completed within 72 hours and can be requested if any of the following applies:

- The Member's treating physician certifies that the Adverse Benefit Determination or Final Adverse Benefit Determination involves a medical condition that could seriously jeopardize the Member's life or health or would jeopardize the Member's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal or a standard external review,
- The Adverse Benefit Determination or Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which the Member received emergency services, but have not yet been discharged from a facility.

External review of experimental and investigational treatment

Requests for standard or expedited external reviews that involve Adverse Benefit Determinations or Final Adverse Benefit Determinations that a treatment is Experimental or Investigational may proceed if the Member's treating physician, who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the Member's condition, certifies:

- The Member has a life-threatening disease or seriously disabling condition; and,
- Medical and scientific evidence, using accepted protocols, shows that the requested health care service is more beneficial to the Member than any standard health care service covered by ConnectiCare, and the adverse risks of the requested health care service are not substantially greater than the standard health care service that is covered by ConnectiCare; and,
- One of the following:
  - Standard health care services have not been effective in improving the Member's condition;
  - Standard health care services are not medically appropriate for the Member; or,
  - No available standard health care service covered by ConnectiCare is more beneficial than the requested health care service.

Request for external review in general

- The Member must request a standard external review within 60 days of the date of the notice of Adverse Benefit Determination or Final Adverse Benefit Determination issued by ConnectiCare. A request for an expedited external review has no filing deadline.

- All requests must be in writing.
- ConnectiCare will initiate the external review by notifying the Connecticut Department of Insurance of the Member's request, which will assign the IRO to conduct the external review. For standard external review requests, ConnectiCare will notify the Member in writing of the assignment to an IRO.
    - The notice will include the name and contact information for the assigned IRO for the purpose of submitting additional information
    - The notice will inform the Member that, within five (5) business days after receipt of the notice, the Member may submit additional information in writing to the IRO for consideration in the review
- ConnectiCare will also forward all documents and information used to make the Adverse Benefit Determination or Final Adverse Benefit Determination to the assigned IRO.
- If ConnectiCare determines that the Adverse Benefit Determination is not eligible for external review, ConnectiCare will notify the Member in writing within five (5) business days of ConnectiCare's receipt of the Member's request for standard external review. For expedited requests, ConnectiCare will notify the Member as quickly as reasonably possible. The notice will provide the Member with the reason for the denial, notify the Member of the director's availability to provide assistance, and provide their phone number and address.
- ConnectiCare will pay the costs of the external review.

IRO assignment

When ConnectiCare initiates an external review, the Connecticut Department of Insurance will utilize an impartial and independent rotational system to assign the review to a Connecticut-accredited IRO that is qualified to conduct the review based on the type of health care service. ConnectiCare will verify that no conflict of interest exists with the IRO.

IRO review and decision

- Within five (5) business days after the IRO's receipt of the Member's request for standard external review, the IRO will determine whether the Member's request is eligible for external review and confirm that all information, forms and certifications were provided. The IRO will notify the Member immediately if additional information is required. If the Member's request is not accepted for standard external review, the IRO will provide the Member and ConnectiCare with written notice explaining the reason. The IRO will notify the Member and ConnectiCare if the Member's request is accepted for standard external review. This paragraph does not apply to expedited external reviews.
- If the IRO is reviewing an Adverse Benefit Determination or Final Adverse Benefit Determination involving an Experimental or Investigational treatment, the IRO will immediately select a clinical peer review panel to conduct the external review upon accepting the Member's request. The panel will be chosen by the IRO and will include experts on the treatment of the Member's condition and the requested health care service. ConnectiCare has the right to request that this panel include at least

three (3) health care professionals who meet these requirements. Each Member of the panel will provide the IRO with a written opinion of whether to uphold or reverse the Member's Adverse Benefit Determination or Final Adverse Benefit Determination.

- The external review decision will be based on the recommendation of the majority of the clinical peer reviewers.
- The IRO must forward, upon receipt, any additional information it receives from the Member to ConnectiCare. At any time, ConnectiCare may reconsider its Adverse Benefit Determination or Final Adverse Benefit Determination and provide coverage for the health care service. Reconsideration will not delay or terminate the external review. If ConnectiCare reverses the Adverse Benefit Determination or Final Adverse Benefit Determination, ConnectiCare will notify the Member and the assigned IRO of that decision within five (5) days for a standard review, and as quickly as reasonably possible for an expedited review. Upon receipt of the notice of reversal by ConnectiCare, the IRO will terminate the review.
- In addition to all documents and information considered by ConnectiCare in making the Adverse Benefit Determination, the IRO must consider things such as the Member's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under this Agreement, the most appropriate practice guidelines, clinical review criteria developed by ConnectiCare, and any additional information or documents that were submitted by the Member. If the review is involving an Experimental or Investigational treatment, the IRO will consider whether the requested health care service is approved by the Federal Food and Drug Administration, or whether medical and scientific evidence demonstrate that the expected benefits of the requested health care service are greater than the benefits covered by ConnectiCare and the adverse risks of the requested health care service are not substantially greater than ConnectiCare's covered services.
- The IRO will provide the Member and ConnectiCare with written notice of its decision within 45 calendar days of its receipt of the Member's request for a standard review. The IRO will provide the Member and ConnectiCare with notice of an expedited review decision within 72 hours of receipt by ConnectiCare of a request for an expedited review. If the expedited review decision is not in writing, written notice will be provided within 48 hours of providing the oral notice. The written notice will include the following information:
  - A general description of the reason for the request for external review.
  - The date the independent review organization was assigned by the Connecticut Department of Insurance to conduct the external review.
  - The dates over which the external review was conducted.
  - The date on which the independent review organization's decision was made.
  - The principal reason for its decision.
  - The rationale for its decision.
  - References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.
  - The written opinions of the clinical peer review panel, if any.
- If the IRO reverses the Adverse Benefit Determination or Final Adverse Benefit Determination, ConnectiCare will approve a covered benefit that was the subject of a

standard request within five (5) business days of ConnectiCare's receipt of the notice from the IRO, and as quickly as reasonable possible for an expedited request, subject to applicable exclusions, limitations, or other provisions.

Binding nature of external review decision

- An external review decision is binding on ConnectiCare except to the extent ConnectiCare has other remedies available under state law. The decision is also binding on the Member except to the extent that the Member has other remedies available under applicable state or federal law.
- The Member may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed.

If the Member has questions about their rights or needs assistance with the internal claims and appeals or external review processes, the Member may contact:

- Phone: (860) 297-3910
- Email: externalreview@ct.gov
- Fax: (860) 297-3872
- Web: ct.gov/cid

Claim disputes/reconsiderations

Providers disputing a claim previously adjudicated must request such action within 90 days of ConnectiCare's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all claim disputes must be submitted on the ConnectiCare Claims Request for Reconsideration Form (CRRF) found on the Provider website and the Availity Essentials portal. The form must be filled out completely in order to be processed. Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The claim number clearly marked on all supporting documents

Requests for claim disputes/reconsiderations should be sent via the following methods:

- Availity Essentials portal: availity.com/providers
  - Navigate to Claims & Payments > Claims Status, then select the claim from the results. On the Details screen, click the Dispute Claim button. After initiating the dispute, open the request, choose the complete dispute modal, enter all required details, and submit.
- Fax: (855) 276-7538
- Mail: U.S. Mail at the following address:
  ConnectiCare Appeals and Grievances
  C/O Firstsource
  PO Box 36030
  Louisville, KY 40233-6030

Please note: Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

The Provider will be notified of ConnectiCare's decision in writing within 90 days of receipt of the claims dispute/adjustment request.

Reporting

Grievance and appeal trends are reported to the Quality Improvement and Health Equity Transformation Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement and Health Equity Transformation Committee for evaluation. If required by the state or CMS, reporting is submitted to the appropriate agency as needed.

15. Credentialing and recredentialing

The purpose of the Credentialing program is to assure that ConnectiCare's network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of ConnectiCare to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your ConnectiCare Provider Relations representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing program has been developed in accordance with state and federal requirements and the standards of the NCQA. The Credentialing Program is reviewed annually, revised and updated as needed.

Non-discriminatory credentialing and recredentialing

ConnectiCare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status or patient types (e.g., Medicaid) in which the Practitioner specializes. This does not preclude ConnectiCare from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Types of practitioners credentialed and recredentialed

Practitioners and groups of Practitioners with whom ConnectiCare contracts must be credentialed prior to the contract being implemented. Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care Practitioners who are licensed, certified or registered by the state to practice independently*
- Chiropractors
- Clinical Social Workers
- Dentists*
- Dieticians/Nutritionists
- Doctoral or master's-level psychologists*
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers*
- Master's-level clinical nurse specialists or psychiatric nurse practitioners*
- Medical Doctors (MD)

- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners/Advanced Practice Registered Nurse (APRN)
- Occupational Therapists
- Optometrists*
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists*
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists*
- Speech and Language Pathologists
- Telemedicine Practitioners

**These practitioner types are credentialed through external vendors.*

Credentialing turn-around time

ConnectiCare fully enrolls/on-boards initial Practitioners within 60 calendar days. The 60 calendar days is measured from the date ConnectiCare receives a full and complete credentialing application.

Criteria for participation in the ConnectiCare network

ConnectiCare has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the ConnectiCare network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the ConnectiCare network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by ConnectiCare.

ConnectiCare reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. ConnectiCare may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of ConnectiCare and the community it serves. ConnectiCare's refusal to waive any requirement shall not entitle any Practitioner to a hearing or any other right of review.

Providers shall not be eligible to see ConnectiCare Members as participating Providers until notified of their effective date from ConnectiCare.

Additionally, Providers shall not be eligible to treat Members as a participating Provider at a location until both notified of credentialing completion and added to the health plan

systems. The Provider will receive a welcome notice from ConnectiCare with the effective date of participation, along with a copy of the fully executed agreement for new contract execution (if applicable). Providers may reach ConnectiCare Provider Relations representatives by calling (800) 828-3407.

Practitioners must meet the following criteria to be eligible to participate in the ConnectiCare network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the ConnectiCare network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the ConnectiCare network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – Practitioners must submit to ConnectiCare a complete credentialing application either from CAQH ProView or other state-mandated Practitioner application. The attestation must be signed within 90 days. Application must include all required attachments.
- **License, certification or registration** – Practitioners must hold a current and valid license, certification or registration to practice in their specialty in every state in which they will provide care and/or render services for ConnectiCare Members. Telemedicine Practitioners are required to be licensed in the state where they are located and the state the Member is located.
- **Drug Enforcement Agency (DEA) certificate** – Practitioners must hold a current, valid, unrestricted DEA certificate. Practitioners must have a DEA certificate in every state where the Practitioner provides care to ConnectiCare Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA certificate or chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **Controlled Dangerous Substances (CDS) certificate** – Practitioners working from Massachusetts and Rhode Island practice locations must meet CDS requirements in that state.
- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to ConnectiCare Members.
- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency training** – Practitioners must have satisfactorily completed residency training from an accredited training program in the specialties in which they are practicing. ConnectiCare only recognizes programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial

Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, Podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board certified, the podiatrist must have five (5) years of work history practicing podiatry.

- **Fellowship training** – Fellowship training is verified when a Practitioner will be advertised in the directory in their fellowship specialty. ConnectiCare only recognizes fellowship programs accredited by ACGME, AOA, CFPC and CODA.
- **Board certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed residency training from an accredited training program in the specialty in which they are practicing. ConnectiCare recognizes certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General practitioners** – Practitioners who are not board certified and have not completed training from an accredited program are only eligible to be considered for participation as a general Practitioner in the ConnectiCare network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. ConnectiCare will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a general Practitioner if the Practitioner is applying to participate as a PCP or as an urgent care or wound care Practitioner. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse practitioners and physician assistants** – In certain circumstances, ConnectiCare may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with ConnectiCare.
- **Work history** –Practitioners must supply the most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.
- **Malpractice history** – Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history

is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- **State sanctions, restrictions on licensure or limitations on scope of practice** – Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing or failure to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
- **Medicare, Medicaid and other sanctions and exclusions** – Practitioners must not be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule or when otherwise declared ineligible from receiving federal contracts, certain subcontracts and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt-out** – Practitioners currently listed on the Medicare Opt-out Report may not participate in the ConnectiCare network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their social security number. That social security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the ConnectiCare network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional liability insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet ConnectiCare criteria. This coverage shall extend to ConnectiCare Members and the Practitioner's activities on ConnectiCare's behalf. Practitioners maintaining coverage under federal

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.

- **Inability to perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of present illegal drug use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal convictions** – Practitioners must disclose if they have ever had any of the following:
  - Criminal convictions, including any convictions, guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes.
  - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
  - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
  - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
  - Any crime related to fraud, kickbacks, healthcare fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances or similar crimes.

  At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or limitations of clinical privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **National Provider Identifier (NPI)** – Practitioners must have an NPI issued by CMS.

Notification of discrepancies in credentialing information and practitioner rights to correct erroneous information

ConnectiCare will notify the Practitioner immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the Practitioner. Examples include but are not limited to actions on a license, malpractice

claims history, board certification actions, sanctions or exclusions. ConnectiCare is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner rights are published on the ConnectiCare website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from ConnectiCare.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Practitioner's response must be sent to:

  Molina Healthcare, Inc.
  Attention: Credentialing Director
  22522 – 29th Drive SE, #L-210
  PO Box 4004
  Bothell, WA 98041

Upon receipt of notification from the Practitioner, ConnectiCare will document receipt of the information in the Practitioner's credentials file. ConnectiCare will then re-verify the primary source information in dispute. If the primary source information has changed, corrections will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within 10 calendar days, their application processing will be discontinued and network participation will be administratively denied or terminated.

Practitioners right to review information submitted to support their credentialing application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the ConnectiCare website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven (7) calendar days to coordinate schedules. A medical director and a director responsible for Credentialing or the Quality Improvement director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the Practitioner are documents which the Practitioner sent to ConnectiCare (e.g., the application and any other attachments submitted with the application from the Practitioner. Practitioners may not copy any other documents from the credentialing file.

Practitioner's right to be informed of application status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner rights are published on the ConnectiCare website and are included in this Provider Manual. ConnectiCare will respond to the request within two (2) working days. ConnectiCare will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Professional review committee (PRC)

ConnectiCare designates a PRC to make recommendations regarding credentialing decisions using a peer review process. ConnectiCare works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to ConnectiCare members. The PRC reports to the Quality Improvement Committee (QIC.) ConnectiCare utilizes information such as, but not limited to credentialing verifications, QOCs and Member complaints to determine continued participation in ConnectiCare's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in ConnectiCare's policy. Please contact ConnectiCare Provider Relations representatives for additional information about fair hearings.

Notification of credentialing decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the ConnectiCare Medical Director within two (2) weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals is not required.

Recredentialing

ConnectiCare recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in Section 1128 of the Social Security Act, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128 or has a contractual relationship with an entity convicted of a crime specified in Section 1128.

Pursuant to Section 1128 of the Social Security Act, ConnectiCare and its Subcontractors may not subcontract with an excluded Provider/person. ConnectiCare and its subcontractors shall terminate subcontracts immediately when ConnectiCare and its subcontractors become aware of such excluded Provider/person or when ConnectiCare and its subcontractors receive notice. ConnectiCare and its subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency. Where ConnectiCare and its subcontractors are unable to certify any of the statements in this certification, ConnectiCare and its subcontractors shall attach a written explanation.

Ongoing monitoring of sanctions and exclusions

ConnectiCare monitors the following agencies for Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when instances of poor quality are identified. If a ConnectiCare Practitioner is found to be sanctioned or excluded, the Practitioner's contract will be immediately terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High Risk List –** Monitor for individuals or facilities who refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions** – Monitor for State Medicaid exclusions through each State's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Monitor for Medicare exclusions through the CMS MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** – ConnectiCare enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

ConnectiCare also monitors the following for all Practitioner types between the recredentialing cycles:

- Member complaints/grievances
- Adverse events
- Medicare opt-out
- Social Security Administration Death Master File

ConnectiCare will monitor the timely renewal of healthcare licenses for all Practitioner types. In the event a Practitioner does not renew their state license prior to the expiration date, ConnectiCare may take action up to and including payment suspension for dates of service on or after license expiration or termination from applicable ConnectiCare provider networks.

Provider appeal rights

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to laws or regulations.

16. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of ConnectiCare. ConnectiCare may delegate:

1. Utilization management
2. Credentialing and recredentialing
3. Claims
4. Complex case management
5. CMS Preclusion List Monitoring
6. Other clinical and administrative functions

When ConnectiCare delegates any clinical or administrative functions, ConnectiCare remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/accountable care organization (ACO)/vendor must be in compliance with ConnectiCare's established delegation criteria and standards. ConnectiCare's Delegation Oversight Committee (DOC) or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with ConnectiCare's standards and best practices.

Delegation reporting requirements

Delegated entities contracted with ConnectiCare must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by ConnectiCare delegation oversight staff for compliance with performance expectations within the timeline indicated by ConnectiCare.

Corrective action plans and revocation of delegated activities

If it is determined that the delegate is out of compliance with ConnectiCare's guidelines or regulatory requirements, ConnectiCare may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. ConnectiCare may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if ConnectiCare determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your ConnectiCare Contract Manager.

17. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. ConnectiCare's goal is to provide our Members with high quality, cost effective drug therapy. ConnectiCare works with our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. ConnectiCare covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T committee is organized to assist ConnectiCare with managing pharmacy resources and to improve the overall satisfaction of ConnectiCare Members and Providers. It seeks to ensure ConnectiCare Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy network

Members must use their ConnectiCare Member ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations and network pharmacies is available by visiting connecticare.com or calling ConnectiCare at (800) 251-7722.

Drug formulary

The pharmacy program does not cover all medications. ConnectiCare keeps a list of drugs, devices and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit connecticare.com.

Information on procedures to obtain these medications is described within this document and also available on the ConnectiCare website at connecticare.com.

Formulary medications

Formulary medications with prior authorization may require the use of first-line medications before they are approved.

Quantity limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on limits are included and can be found in the formulary document.

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step therapy

Plan restrictions for certain formulary drugs may require that other drugs be tried first. The formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with ConnectiCare shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining ConnectiCare, documentation in the clinical record can serve to satisfy requirements when submitted to ConnectiCare for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Non-formulary medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a Prior Authorization Request Form which is available on the ConnectiCare website at connecticare.com. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of a manufacturer's samples of non-formulary or "prior authorization required" medications does not override formulary requirements.

Generic substitution

Generic drugs should be dispensed when available. If the use of a particular brand name becomes medically necessary as determined by the Provider, prior authorization must be obtained through the standard prior authorization process.

New-to-market drugs

Newly approved drug products will not normally be placed on the formulary during their first six (6) months on the market. During this period, access to these medications will be considered through the prior authorization process.

Medications not covered

Medications not covered by ConnectiCare Marketplace are excluded from coverage. For example, drugs used for weight loss or those used for cosmetic purposes are not part of the benefit. For a complete list of drugs excluded from the plan benefit please refer to the Member's Evidence of Coverage.

Submitting a prior authorization request

ConnectiCare's vendor, CVS Caremark, will only process completed prior authorization request forms, the following information MUST be included for the request form to be considered complete.

- Member first name, last name, date of birth and ConnectiCare Member ID number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Electronic prior authorization (ePA): SureScripts® and CoverMyMeds

CVS Caremark's decisions are based upon the information included with the prior authorization request. Clinical notes are recommended. If clinical information and/or medical justification is missing CVS Caremark will either respond via the electronic prior authorization (ePA) portal, fax, or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the Pharmacy Preauthorization Form in its entirety, including medical justification and/or supporting clinical notes.

CVS Caremark utilizes ePA portal submissions through the SureScripts® and CoverMyMeds® platforms that are integrated into physician office electronic health record (EHR) systems. The ePA portal automates the prior authorization process, making it a quick and simple way to complete prior authorization requests. The ePA portal process is HIPAA-compliant and can enable faster coverage determinations. For select drugs and plans, CoverMyMeds® may issue immediate approval of your request and update your patient's prior authorization record to allow immediate claim adjudication.

Fax a completed Pharmacy Preauthorization Form to CVS Caremark at (833) 896-0676. A blank Pharmacy Preauthorization Form is available on ConnectiCare's website at connecticare.com or by calling CVS Caremark at (888) 407-6425.

Providers and office staff can review ConnectiCare clinical Criteria and Clinical Policies online to ensure all required information is submitted for review.

Site of care for administered drugs

For Provider-administered drugs that require prior authorization, when coverage criteria are met for the medication, a site of care policy is used to determine the medical necessity of the requested site of care. ConnectiCare covers injectable and infused medications in an outpatient hospital setting or at a hospital-affiliated infusion suite when the level of care is determined to be medically necessary. To review the site of care policy, please visit ConnectiCare's website at connecticare.com.

ConnectiCare may conduct peer-to-peer discussions or other outreach to evaluate the level of care that is medically necessary. If an alternate site of care is suitable,

ConnectiCare may offer the ordering Provider help in identifying an in-network infusion center, physician office or home infusion service and will help the Member coordinate and transition through case management.

Member and provider “patient safety notifications”

ConnectiCare has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA-required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA-accredited organization.

Specialty pharmaceuticals, injectable and infusion services

Many specialty medications are covered by ConnectiCare through the pharmacy benefit using NDC for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications may be covered through the medical benefit using HCPCS via electronic medical claim submission.

During the utilization management review process, ConnectiCare will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any federal or state regulatory requirements and the Member specific benefit plan coverage prior to determination of benefit processing.

If it is determined to be a pharmacy benefit, ConnectiCare’s pharmacy vendor will coordinate with ConnectiCare and ship the prescription directly to your office or the Member’s home. All packages are individually marked for each Member and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your ConnectiCare Provider Relations representative with any further questions about the program.

Newly FDA-approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the ConnectiCare Pharmacy and Therapeutics Committee. “Buy-and-bill” drugs are pharmaceuticals which a Provider purchases and administers and for which the Provider submits a claim to ConnectiCare for reimbursement.

ConnectiCare clinical services completes utilization management for certain healthcare administered drugs. For any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require prior authorization for such drug even after it has been assigned a new HCPCS code, until otherwise noted in the prior authorization list.

Pain safety initiative (PSI) resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. ConnectiCare requires Providers to adhere to ConnectiCare's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding opioid and pain safety as needed.

ConnectiCare is dedicated to ensuring Providers are equipped with additional resources, which can be found on the ConnectiCare Provider website. Providers may access additional opioid-safety and substance use disorder resources at connecticare.com. Please consult with your ConnectiCare Provider Relations representative or reference the medication formulary for more information on ConnectiCare's pain safety initiatives.

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